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THE DIAGNOSIS AND TREATMENT OF SOFT PART SARCOMAS*

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A better introduction to sarcomas of soft tissue origin cannot be given than that of Doctor Arthur Purdy Stout who, in speaking of these lesions, said: "The common malignant tumors are advertised to the public and their recognition and treatment, morbidity and mortality, incidence and etiology, experimental study, and every other phase of them now receive intensive, ceaseless attention. But the uncommon tumors, unless they happen to be hormonally active or to involve a popular organ like the ovary, are still relatively unknown, poorly understood and, as a natural consequence, generally badly treated."[30]

Sarcomas of soft tissue origin are not common. Exact figures of the incidence, prevalence and total case rate of these tumors in the population as a whole are not at hand. Several excellent statistical studies of the occurrence of cancer in certain localities in the United States are available and provide the figures contained in Table I. It will be seen that probably 2 to 4 new cases of soft part sarcoma may be expected in each group of 100,000 persons per year. Although the individual practitioner will, therefore, infrequently encounter these tumors, they present an interesting group of neoplasms whose diagnosis is not difficult and whose treatment is often rewarding.

TABLE 1
SOFT PART SARCOMAS
Patients per 100,000 population per year

	Incidence	Prevalence	Total Case Rate
Atlanta, 1947[5]	1.9	2.5	---
San Francisco, 1947[6]	4.1	5.2	---
New Orleans, 1947[7]	2.2	3.6	---
Connecticut, 1940-1946[12]	2.3	--	23.4
Onondaga County, N.Y.[32] 1940-46	--	3.8	---

Dorn[9] defines the above headings as follows: *Incidence* is the relative number of cases first diagnosed in a given year; *Prevalence* is the relative number of cases diagnosed or treated at any time during the year; and *Total Case Rate* is the relative number of cases diagnosed, treated or being observed only during the year.

In an institution specializing in the treatment of cancer, however, these tumors are seen with greater frequency and in greater number. The following review is based on the composite experience of the Mixed Tumor Service at Memorial Hospital in the management of more than 700 cases of soft part sarcoma encountered from 1926 through 1951.

DIAGNOSIS

As with many forms of cancer the early diagnosis of sarcomas of the soft tissue depends on a high degree of suspicion that cancer may be present. There is no finding pathognomonic of a soft part sarcoma. A review of the more common symptoms and signs is noteworthy for its brevity:

Symptoms: A non-tender, progressively enlarging mass in skin, subcutaneous tissue, or deeper structures is the only complaint offered by the average patient. Its duration and rate of growth, if short and rapid, may strongly suggest sarcoma, but this symptom must be evaluated dispassionately since patients are notoriously inaccurate in matters of time and dimension. If the mass happens to be so situated as to interfere with the anatomical or functional integrity of contiguous structures or organs, symptoms referable to the displaced or deranged structure may assume prominence. Thus, a patient may complain of "varicose veins" in an extremity in which a sarcoma by its size and location has obstructed the venous return. Or, by pressure on or invasion of a nerve trunk, a sarcoma may give rise to symptoms of neuralgia throughout the area normally supplied by the nerve. Sarcomas arising near joints may by their space-occupying characteristics produce restriction of motion at the joint.

A history of injury to the area prior to or con-

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comitant with the development of a sarcoma is mentioned by the patient with sufficient frequency to warrant comment. While no one can positively deny that a sarcoma may arise from single, acute trauma, it is generally agreed that such etiology is unlikely. Rarely, indeed, can any tumor satisfy the Segond[23] postulates and be accepted as traumatic in origin. While sarcomas appear more frequently to have an antecedent history of trauma than carcinomas, this is probably explained by the frequent location of sarcomas in the extremities and exposed areas of the body which are necessarily more subject to acute trauma than are the viscera where carcinoma is more common. To explain most of the alleged post-traumatic neoplasms, the late Doctor James Ewing introduced the concept of "traumatic determinism", by which is meant the tendency of a part already harboring a neoplasm to be subject to injury which, in turn, leads to recognition of the tumor.

Signs: The recognition of a superficial soft tissue mass is readily accomplished, while palpation of a deeper-lying tumor may require the physician to examine a patient in several positions with attention directed toward relaxing normally tensed joints, fascial sheets, and muscle bundles. The size of a mass is obviously of little diagnostic consequence since this will vary directly with the duration of the tumor.

The physical characteristics of a soft tissue mass, on the other hand, may be of some diagnostic significance since benign tumors in general tend to be well-encapsulated, homogenous throughout and freely movable over deeper structures, while sarcomas often present indefinite outline, variation in consistency and some degree of fixation to underlying structures as well as to overlying skin.

Laboratory Studies: Roentgenograms of the affected area may on occasion contribute to the establishment of a diagnosis. A benign soft tissue tumor will frequently appear as a discreet, well-demarcated area of water density in soft-tissue films. Sarcomas may be suspected when soft tissue swelling is evident with no discreet mass discernible in the roentgenogram. Evidence of soft tissue calcification may be suggestive of certain sarcomas, such as extraosseous osteogenic sarcoma, neuroblastoma, and occasionally synovial sarcoma, but may also be seen in deep-lying angiomas,[11] as well as in certain non-neoplastic diseases, such as myositis ossificans. Histologic study of representative material from a soft tissue tumor is the only laboratory procedure of diagnostic importance.

Biopsy: When a soft part sarcoma is suspected, diagnosis must be established by biopsy before definitive treatment is undertaken. If a sarcoma has ulcerated through the overlying skin, a satisfactory biopsy often may be obtained without anesthesia from the area of fungation. Biopsy under anesthesia is, however, usually required. Depending upon the size of the tumor, either incisional biopsy or excisional biopsy may be performed. Incision is made over the lesion through skin which, if sarcoma is proved to be present, is subsequently to be sacrificed surgically or to be included within a field of radiation. In large tumors a generous wedge of tissue is removed from the mass, hemostasis secured, and the wound closed without drainage. In small tumors the entire mass may be removed for biopsy, hemostasis secured, and the wound closed without drainage. In the latter instance in which local enucleation of the entire mass is performed, it cannot be sufficiently emphasized that definitive treatment has thus NOT been accomplished. In spite of the pseudo-encapsulation of many sarcomas, the high incidence of recurrence following local excision demands that further treatment be carried out.

Aspiration biopsy, which has the advantage of simplicity and ease of performance under local anesthesia, may be employed for diagnosis in certain instances. Although theoretical objections to aspiration biopsy have been voiced, we have seen no undesirable complications directly attributable to this diagnostic procedure when properly employed. The limitations of aspiration biopsy are real, however. Many pathologists are unwilling to render opinion on material so obtained. Furthermore, it is often impossible thus to secure accurate histologic (contrasted with cytologic) classification on which may depend the form of definitive treatment subsequently to be instituted.

TREATMENT

Although it is the opinion of many physicians that certain forms of cancer are essentially incurable because of their extremely poor survival rate irrespective of treatment administered, and that to treat such forms of cancer with the intention of cure is unrealistic and unwarranted, it is our opinion that such a negativistic approach is untenable even if only one patient in a hundred may be cured. Sta-

tistics are misleading when applied to a single individual, for that one patient may be the sole survivor who is necessarily as completely and permanently cured as the other 99 patients are not. Even if the difference between 99 fatalities and 100 fatalities is negligible to the statistician, how much to the contrary it is to the one patient who, by aggressive and adequate treatment is cured!

Akin to the therapeutic nihilist is the physician who employs the fallacious principle of a small operation for a little cancer and a big operation for a big one, or who indulges in the hope that a given cancer may be a "favorable" one so that radical or mutilating therapy can be avoided. By such attitudes a patient may well be deprived of his chance for cure.

For the patient with a localized soft tissue sarcoma, treatment must be accurate, aggressive and adequate. Accurate therapy implies a knowledge of the histologic pattern of the neoplasm from which can be deduced its probable characteristics of growth and behavior. Aggressive therapy requires that the physician have a clear understanding of the malignant potentialities of the tumor, regardless of its apparent small size or innocuous course to the time of treatment. Adequate therapy can only be interpreted as that which will effect local eradication of the lesion. When local control of a tumor has been achieved, the subsequent development of distant metastases cannot be strictly considered evidence of failure in treatment method. Local recurrence of the tumor after treatment, however, can only be interpreted as proof of indifferent, inadequate treatment. In some instances adequate treatment may still be offered a patient with local recurrence of sarcoma. Nevertheless, in many instances, local recurrence gives rise to, or is coincident with, disseminated metastases which doom further treatment to ultimate failure although effective palliation may sometimes be accomplished.

Surgical Treatment: In general, it may be said that sarcomas arising from fibrous tissue, from heterotopic bone and cartilage, from smooth and striated muscle tissue and from peripheral nerve tissue (i.e., fibrosarcoma, extra-osseous osteogenic sarcoma, leiomyosarcoma, rhabdomyosarcoma and malignant neurilemoma) require surgical treatment in order to offer the patient a chance for cure. Sarcomas arising from adipose tissue, from vascular tissue and from synovial tissue (i.e., liposarcoma, angiosarcoma and synovial sarcoma) usually are best treated by surgery. Surgical treatment of soft tissue sarcomas require the surgeon to perform more or less mutilating procedures as a rule. Accumulating evidence indicates that many sarcomas spread by direct extension along contiguous fascial planes and muscle fasciculi (Fig. 4). It is our belief, therefore, that adequate resection of a soft tissue sarcoma entails wide sacrifice of surrounding soft tissue, including fascia and entire muscle bundles at their points of origin and insertion. Optimally, this should be accomplished without exposing recognizable tumor at any point of the procedure. Depending, therefore, upon the anatomical location of the tumor, adequate surgical treatment may be accomplished in some instances by radical block resection of soft tissue (Fig. 1), while in other instances amputation is required (Fig. 2).

To lessen the possibility of mechanical dissemination of neoplastic cells from operative manipulation, it is desirable, when technically feasible, to ligate the major venous tributaries draining the site of sarcoma early in the operative procedure, or, failing this, to employ a venous tourniquet proximal to the operative field. The advantages of either of these methods are admittedly theoretical. In practice these advantages are probably achieved by beginning the surgical dissection proximal and proceeding distally.

Radiation Therapy: As with surgical treatment, a preliminary biopsy is obligatory in order to establish not only the presence of sarcoma but its histologic type as well. In general, it may be stated that sarcomas arising from undifferentiated mesenchymal tissue and from lymphatic and reticuloendothelial tissue (i.e., neuroblastoma, lymphocytoma and reticulum-cell sarcoma) are best treated by radiation therapy. In liposarcoma, angiosarcoma and synovial sarcoma, radiation therapy may be employed under certain circumstances but rarely with the hope of cure. Some highly anaplastic sarcomas of uncertain histogenesis may also be thus effectively treated.

Aggressive radiation therapy requires formulation of a specific plan of treatment with due consideration of physical factors employed. Attention must be directed to daily and total dosage and time factors, as well as to size and number of radiation portals so as to provide radiation saturation of all tissues invaded by neoplastic cells. To sterilize the central area of the tumor by x-ray but to allow

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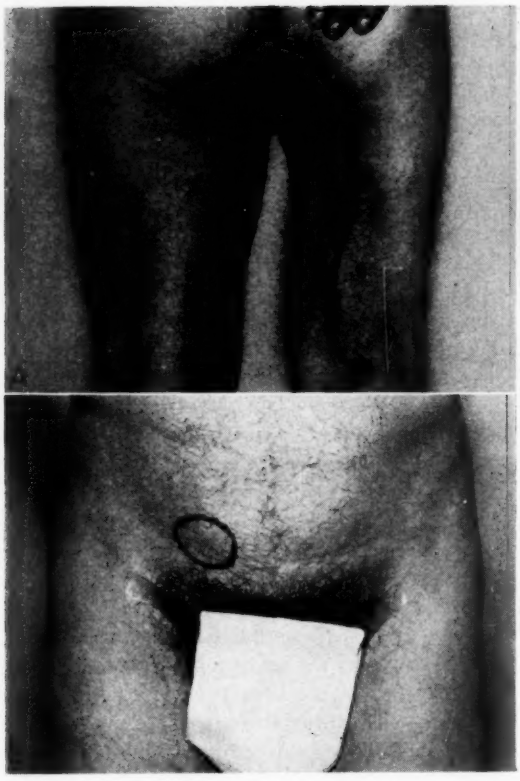

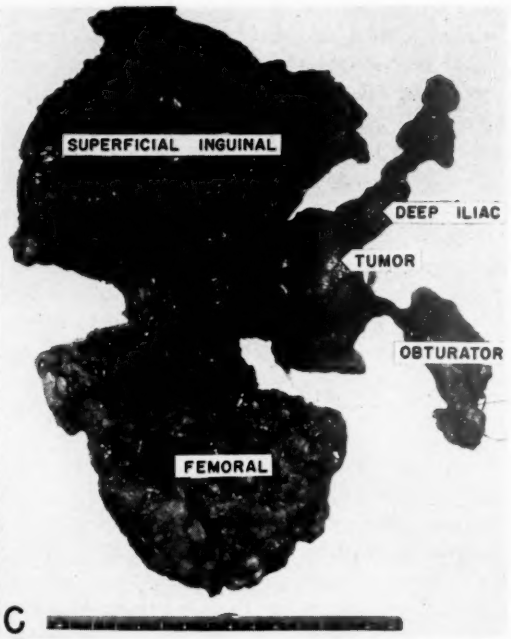

Fig. 1.—R. B. (A) Surgical scar of right posterior thigh following resection of muscle, fascia and subcutaneous tissue of posterior compartment for rhabdomyosarcoma arising in short head of biceps femoris. (B) Palpable right lower quadrant mass, indicated by skin mark, noted 14 months following above-described resection. (C) Surgical specimen of the right radical groin dissection, demonstrating metastatic rhabdomyosarcoma in right external iliac node, removed 14 months following control of primary tumor.

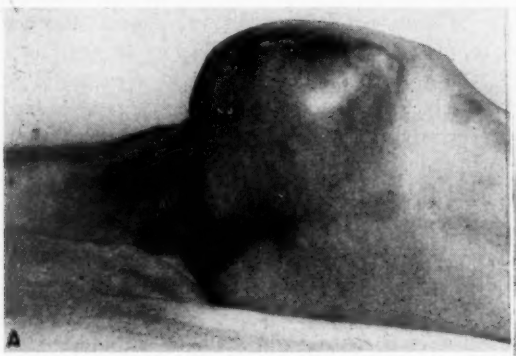

Fig. 2.—S. F. (A) Huge recurrent malignant neurilemoma of the left buttock, believed to have developed in a pre-existing benign neurofibroma. Note café-au-lait skin pigmentation characteristic of generalized von Recklinghausen's disease. (B) Surgical specimen following left hemi-pelvectomy, demonstrating intrapelvic extension of tumor (from Bowden, L., and Booher, R. J., *Surgical Considerations in the Treatment of Sarcoma of the Buttock*, Cancer 6:89-99, 1953).

its periphery to propagate accomplishes little for the patient. To produce permanent local eradication of tumor by radiation therapy requires inevitably a protracted and faithfully continued program. This will, incidentally, cause desquamation of overlying skin with slow subsequent healing. The late sequelae of radiation therapy, including radiation osteitis, subcutaneous fibrosis, skin telangiectasia and atrophy, must also be anticipated.

A belief commonly held by physicians and laymen alike that radiation therapy is an easier form of treatment than surgery is questionable. From the patient's standpoint, curative irradition requires daily visits to the roentgenotherapist for several weeks, followed by an equal length of time, as a rule, of semi-invalidism while radiation reaction subsides and healing occurs. Annoying symptoms of "radiation sickness" may be experienced by the patient, as well as the late sequalae of intensive irradiation already mentioned. From the therapists' standpoint, curative irradiation requires most careful planning of cross-firing beams so as to deliver adequate x-ray to center and periphery alike, as well as daily personal attention to make sure this plan is effected.

Combined Irradiation and Surgery: It should be stated at once that inadequate surgical treatment combined with inadequate radiation treatment has never been known to effect a cure of cancer. Nevertheless, recent reports indicate that combined radiation and surgical therapy may be used to advantage under certain circumstances . In this country, Pack and Miller[15] have reported their experiences in rendering primarily inoperable lesions operable by preliminary roentgenotherapy. In England, Sir Stanford Cade,[4] in reporting experience with 153 patients with soft part sarcomas, noted better results in the patients given sublethal protracted irradiation preceded or followed by surgery than in those in whom surgery alone was employed. He proposes that such irradiation, by virtue of chromosomal break and gene mutation in the cancer cell, destroys its power of propagation even though the cell itself remains viable. We are inclined to believe that the occasional good result we have achieved in "radio-resistant" sarcoma by means of sublethal irradiation and surgery would probably have been obtained by surgery alone. Nevertheless, the occasional case is seen in which surgery is out of the question until radiation therapy has been first administered (Fig. 3).

Treatment of Metastases: It is a well recognized fact that soft part sarcomas classically spread via the blood stream. It is not so well recognized, however, that soft part sarcomas may spread via lymphatics to lymph nodes or that these tumors may spread by direct extension along muscle bundles and fascial planes (Fig. 4).

Treatment of such local spread along muscle and fascial planes should be accomplished simultaneously with control of the primary tumor, whether treatment be by surgery or by irradiation.

Sarcomatous lymph node metastases occur in perhaps 5% to 25% of patients with reticulum-cell

Fig. 3.—J. M. (A) Recurrent myxoliposarcoma of the left buttock following preliminary radiation therapy and prior to surgical resection. (B) Twenty-six months following radical local resection of the left buttock (from Bowden, L., and Booher, R. J., *Surgical Considerations in the Treatment of Sarcoma of the Buttock*, Cancer 6:89-99, 1953).

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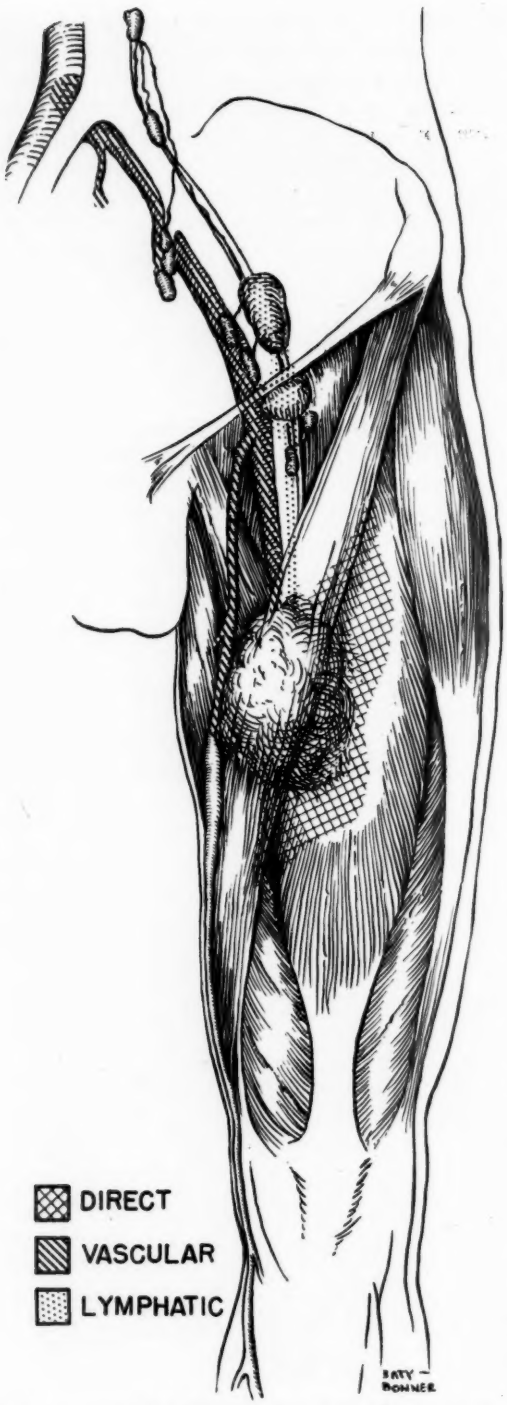

Fig. 4.—Anatomical diagram indicating the three modes of spread of soft tissue sarcoma of the thigh.

sarcoma, synovial sarcoma, angiosarcoma and rhabdomyosarcoma, and are not unknown in fibrosarcoma and in liposarcoma. For this reason, careful examination of regional node areas should be performed in all patients with sarcoma. Regional node removal is routinely accomplished in many disarticulations (e.g. interscapulothoracic amputation, or hemipelvectomy). In more conservative amputations for sarcoma, as well as in extensive local resections for sarcoma, a regional node dissection may well be included as part of the operative procedure. Whether treatment of the primary sarcoma has been by irradiation or by surgery, surgical dissection of the entire node-bearing area is indicated as a rule when regional node metastases subsequently develop (Fig. 1). Roentgentherapy for sarcomatous node metastases in lymphocytoma and neuroblastoma is usually effective, and occasionally effective in node metastases from reticulum-cell sarcoma but is infrequently effective in node metastases from other soft part sarcomas.

When soft part sarcomas spread via the blood stream, there is usually widespread dissemination of tumor and cure is impossible. Nevertheless, solitary pulmonary metastasis does occur with sufficient frequency to be noteworthy. Furthermore, the striking long term survival in some instances following pulmonary resection for solitary sarcomatous metastasis demands aggressive treatment should this complication develop. Seiler[24] and his associates have reviewed a total of 62 reported instances of pulmonary resection for metastatic tumors, of which 18 were done for metastatic sarcoma. Three of these 18 patients were living and well for five or more years, while 7 more were free of cancer for varying periods of less than five years. Stereoscopic chest films, and frequently tomograms of the chest, are required to exclude the presence of other unsuspected metastases before thoracotomy is undertaken for resection of a solitary metastasis (Fig. 5).

Palliative Treatment: In treating potentially curable cancer the physician's therapeutic considerations should be confined primarily to the cancer itself, while in treating disseminated incurable cancer his attention should be focussed primarily on the patient as an individual. In applying this rule, it is noteworthy that sometimes the best palliative treatment is actually no treatment at all. Usually, however, palliative treatment includes the maintenance of adequate nutrition, the relief of pain, the

correction of anemia and the bolstering of morale.

In order to accomplish these ends, both palliative surgery and palliative roentgenotherapy must sometimes be employed. Untreated sarcoma frequently invades and ulcerates the overlying skin and, because of superimposed infection or because of invasion of sensory nerve trunks, to say nothing of blood and fluid loss from areas of fungation, and offensive odor, palliative surgery or x-ray treatment is definitely indicated. It should again be emphasized that effective palliative treatment requires evaluation of the patient as a whole and treatment of symptoms as they develop (Fig. 6).

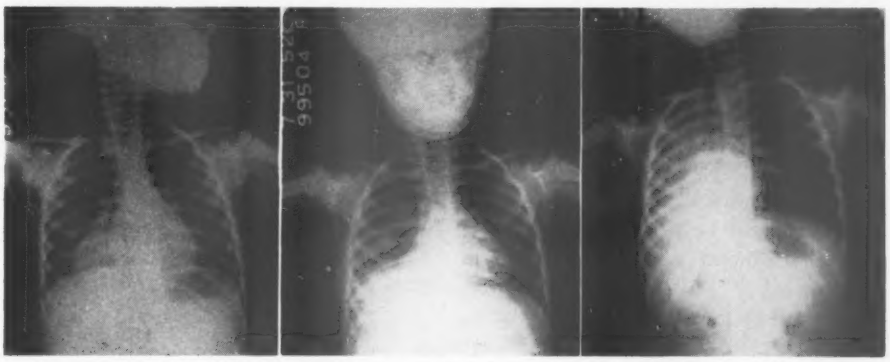

Fig. 5.—L. R. Sequential chest roentgenograms of a 3-year old child surgically treated 11 months previously for a rhabdomyosarcoma of the right buttock. The first film demonstrates a solitary right lower lobe metastasis, the second film the appearance of the chest 7 days following the right lower lobectomy and the third film the appearance of the chest six months later. Although somewhat limited in physical activity because of the marked (and unexplained) mediastinal shift, this child remains free of demonstrable tumor 18 months following her pulmonary resection.

RESULTS OF TREATMENT

Of the 717 patients with sarcoma of the soft tissues treated at Memorial Hospital since 1926, there is a group of 418 patients who were treated more than five years ago and have been sucessfully followed since. The over-all five-year salvage rate in this determinate group of 418 individuals is 39.2%.[21] The salvage rate varies markedly with the type of sarcoma treated, ranging from a low of 21.6% in

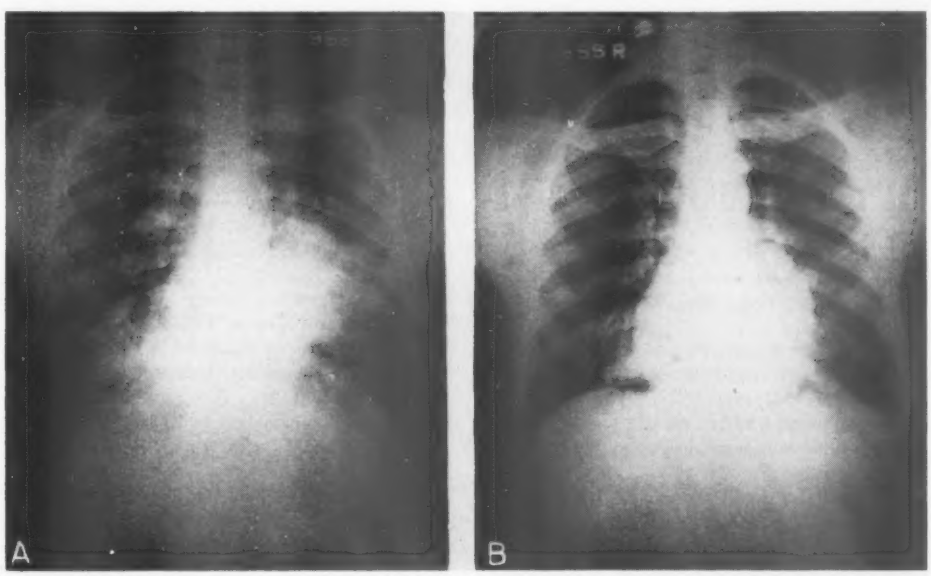

Fig. 6.—S.G. (A) Chest roentgenogram demonstrating diffuse pulmonary metastases of fibrosarcoma in a patient with hemoptysis and progressive dyspnea. (B) Appearance of chest after 5 weeks of palliative roentgenotherapy, showing marked regression of metastases. This was hardly expected in a characteristically radio-resistant tumor! Effective palliation was thus afforded the patient for almost 6 months.

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synovial sarcoma[14] to a high of 69.2% in dermatofibrosarcoma protuberans.[16]

If an over-all five-year salvage of 39.2% can be obtained by accurate and aggressive treatment of soft part sarcomas, it behooves every practitioner to see that such therapy is afforded the occasional patient whom he encounters with this type of tumor.

SUMMARY

Sarcomas of soft tissue origin are relatively uncommon but are not difficult to diagnose and are often rewarding to treat. A high degree of suspicion that a painless soft tissue mass of uncertain outline and unusual consistency may be a sarcoma is the key to prompt diagnosis. Biopsy must be performed to prove the diagnosis.

Treatment of soft part sarcomas must be accurate, aggressive and adequate. Either surgery or irradiation, or a combination of these two, may be the treatment method employed, depending upon the histogenesis, location and extent of the lesion.

In the Memorial Hospital experience with more than 700 cases of soft part sarcoma, 418 patients were treated five or more years ago, providing a sizable group of patients on which to base end-result figures. One hundred sixty-four of these patients remained free of tumor for five or more years, giving an over-all salvage of 39.2%.

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HEMOLYTIC DISEASE OF THE NEWBORN

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Although a vast amount of literature has appeared on the problem of isosensitization and hemolytic disease of the newborn, the general practitioner does not have the time to acquaint himself with all of the varied genetic, laboratory and clinical aspects of the problem. Presented here are a few guideposts that may help in diagnosis and treatment.

From the obstetrical point of view, it is of interest to note that, although less than 5% of Rh negative women are immunized by pregnancy alone, this figure rises to 50% when there is a history of incompatible Rh blood transfusion. The antigen of greatest clinical importance is the D antigen (the original Rh factor). Anti-D alone or in combination with other antibodies is found in the maternal serum in over 98% of cases of hemolytic disease of the newborn. However, Rh iso-immunization of the mother is not necessarily synonymous with hemolytic disease in the offspring as the maternal antibodies may be due to a previous pregnancy or transfusion and the child may be Rh negative and as such completely unaffected by the maternal antibodies or the titer of the antibodies may not have reached a level where they can produce the clinical picture of the disease. There is a tendency, nevertheless, for the disease to become progressively more severe in succeeding pregnancies and, where a hydropic infant has been born and the father is known to be homozygous, there is little chance to salvage any future children from this mating.

Unfortunately at the present time, there is no sure means of preventing or even depressing antibody production by the mother. At one time, the early induction of labor in immunized mothers, in order to remove the children from its unfavorable environment, was considered the best means of insuring a living child. However, the final outcome depends to a large extent on the capacity of the liver to deal with the products of hemolysis and the premature child has a much reduced capacity to handle this problem than does the full term child. Furthermore, it has been demonstrated that the incidence of kernicterus is higher in the premature infant than in the full term infant.

Procedures that may prove of benefit to the infant are: (1) all pregnant women shonld be Rh typed at the time of the first examination and, if Rh negative, complete antibody studies should be carried out. Depending on the parity of the patient and the history of previous transfusions, antibody studies should be done at frequent intervals thereafter; (2) if an exchange transfusion is anticipated, rapid clamping of the cord should be done so that very little of the placental blood is pumped over into the infant's circulation; (3) analgesics for the mother should be used sparingly so that anoxia in the child may be reduced to a minimum, and (4) probably of most importance, that close cooperation should be established with the pediatrician so that suitable therapy may be instituted rapidly. An exchange transfusion soon after birth may prove to be lifesaving.

From the pediatric point of view the diagnosis of hemolytic disease may present some difficulties, especially where adequate laboratory facilities are not available. In instances where the development of hemolytic disease of the newborn can be anticipated, the premature infant especially should receive the benefit of prompt therapy.

The need for therapy and the type of therapy to be instituted depends upon a number of factors and these will be considered in the following order:

1. Duration and height of maternal antibody titer.
2. History of previous hemolytic disease and homo or heterozygosity of the father.
3. Prematurity.
4. Laboratory findings on the infant:
   Coomb's test
   cord hemoglobin
   serum bilirubin
   reticulocytosis and erythroblastemia.
5. The exchange transfusion.

1. Although one cannot predict the degree of the hemolytic process in the infant from the maternal antibody titer alone, a titer of 1:32 or higher, especially when the antibodies are of the incomplete or blocking variety, usually results in some degree of sensitization of the infant's cells. If a high titer

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of antibodies has persisted throughout the pregnancy, the infant is apt to be more severely affected than if the antibodies first appeared in the last trimester.

2. Hemolytic disease usually becomes progressively more severe in subsequent pregnancies although this is not always the case. However, if the mother has already given birth to an affected infant, the outcome of future pregnancies will depend upon the genetic make-up of the father. If the father is homozygous, all of the children will be Rh positive and subject to the hemolytic process, whereas, if he is heterozygous, there is a 50-50 chance of the child being Rh negative and therefore unaffected.

3. Premature infants are in need of more prompt and intensive transfusion therapy because of their lesser ability to handle the products of hemolysis and because of their greater susceptibility to kernicterus.

4. Laboratory findings on the infant will often permit the institution of suitable therapy long before the clinical signs of anemia and jaundice become apparent. Early therapy is especially important in the prevention of kernicterus or the neurological sequelae that may follow hemolytic disease of the newborn.

The Coomb's test: Coomb's serum is an anti-globulin serum that brings about the clumping of red blood cells that have antibody globulin attached to them. The antibody need not be anti-Rh in specificity. The Coomb's test is one of the most useful tests for the diagnosis of hemolytic disease of the newborn. It can be performed on as little as one drop of whole blood and in as short a time as 5 minutes. A positive Coomb's test indicates sensitization of the infant's cells with maternal antibody and such cells are labelled for destruction. On occasion, an Rh positive infant may type falsely as Rh negative due to the blocking action of the maternal antibodies on the infant's cells; however, in the presence of a positive Coomb's test the true situation is apparent. Hemolytic disease rarely occurs in the absence of a positive Coomb's test. Although the test will decide whether or not the child's cells are coated with antibody, it will not in itself indicate the degree of the hemolytic process nor prognosticate the future course of the disease.

The cord hemoglobin: Many workers have found that the cord hemoglobin level is very closely related to the infant's chance for survival and that it is the best index for deciding on the type of therapy, i.e., simple transfusion or the exchange transfusion. A 68% mortality has been demonstrated for infants whose cord hemoglobins were under 10.0 Gms.%. Exchange transfusions are advocated for all infants whose cord hemoglobins are below 13.0 Gm.%. This criterion will not hold true for hemoglobins performed on peripheral blood, since such values tend to be higher. Infants whose cords are tied early will show a lower venous hemoglobin concentration than infants whose cords are tied late.

The serum bilirubin level: There also appears to be a correlation between the cord bilirubin level and the chance for survival and incidence of kernicterus. Mollison reported a 52% mortality when the level of the cord bilirubin exceeded 4.0 mg.%. The bilirubin level at birth is not a good index for treatment, as treatment should be instituted long before the peak of the bilirubin level is reached many hours after birth. Hsia and associates studied the bilirubin levels in infants at birth and after exchange transfusions, and they stressed the need for keeping a close check on the serum bilirubin. It is their opinion that kernicterus can be prevented if the level of the bilirubin is kept below 20.0 mg.%. Multiple exchange transfusions are recommended, if necessary, to maintain bilirubin level below 20.0 mg.%.

Reticulocytosis and erythroblastemia: In infants showing hemoglobin levels in the normal range, the reticulocyte and erythroblast level may help in foretelling increased blood destruction. If the cord hemoglobin is 15.0 Gms.% or more, the reticulocyte count normal (less than 5%), and the erythroblast count normal (less than 10 per 100 white cells) the infant is almost sure to recover without treatment.

5. The use of exchange transfusion has reduced the mortality due to hemolytic disease and has lowered the incidence of kernicterus in the surviving infants. Criteria for the exchange transfusion, based on an extensive series of cases, have been established by Allen and associates.

(a) Any infant showing hepatosplenomegaly, edema or anemia (less than 4.5 million R.B.C.)

(b) Exchange at any time when the infant's serum bilirubin level exceeds 20.0 mg.%, using multiple exchanges if necessary. However, an exchange transfusion will be most effective if done within the first 24 hours after birth.

(c) Exchange if other findings are equivocal and the child is premature.

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(d) Exchange if there is a history of hemolytic disease in the family and especially if the infant is a male. Allen reported an incidence of 8.9% kernicterus in females and 17.8% in males.

In addition to the above criteria, if the mother's titer is 1:32 or higher and if the baby has a positive Coomb's test and its cord hemoglobin level is below 13 Grams, an exchange transfusion is generally advisable.

The obstetrician who has done antibody tests on his patient during pregnancy will be in a position to arrange for a prompt exchange transfusion immediately after delivery. Ideally, blood should be obtained from the mother prior to delivery and cross matched with a compatible donor. In this way suitable blood for exchange transfusion will be made available at the time of delivery.

In those rare instances in which an antibody is encountered with a high incidence of positive reactions, additional time will be available for the blood bank to find a compatible donor.

TECHNIQUE OF THE EXCHANGE TRANSFUSION

If one exchanges 500 cc. of blood, a removal of about 95% of the Rh positive blood can be accomplished. The positive Coomb's test will also generally be reversed.

Regardless of the method of exchange, the following precautions should be taken:

1. Fresh Rh negative blood must be obtained—the best test for compatibility of the blood is a cross match between the donor's cells and mother's serum.
2. Baby kept warm during procedure and the blood brought to room temperature to prevent chilling.
3. Aseptic technique used at all times—operating room helpful.
4. Heparin, .1 cc., given I.V. with each 100 cc. of blood to prevent blood clotting.
5. 10% calcium gluconate, 1 cc., given I.V. per 100 cc. of blood because of the citrate in blood predisposing to tetany.
6. Vitamin K should be given following the exchange to restore blood clotting to normal.
7. Prophylactic penicillin is also given 24-48 hours following exchange.

Exchange transfusion is generally accomplished by one of the following methods:

1. Umbilical vein technique
2. Great saphenous vein technique
3. Radial artery—saphenous vein technique.

The umbilical vein technique can be carried out for about 24-48 hours after birth. The other techniques can be carried out at any time following delivery.

Umbilical vein catheterization with polyethylene tubing was first introduced by Diamond in 1947. As large a polyethylene tube as possible is introduced into the stump of the umbilical cord which in turn enters the portal vein. The umbilical vein is the largest vessel present in the umbilical stump. Because of the tortuosity of the umbilical vein it is at times helpful to cut the umbilical cord down close to the skin level. The actual catheterization of the vein can sometimes be accomplished easily and at other times can be difficult, depending on the tortuosity of the vessel. A three-way stop cock is attached to the polyethylene tube and the other two connections attached to the blood for transfusion and the other to a 20 cc. syringe. By manipulating the three-way stop-cock, blood can be injected and withdrawn through the polyethylene tube. The hazards of the umbilical vein technique are air embolism, perforation of the umbilical vein or portal vein, sepsis, overloading of the circulation and tetany.

Bukot, Arnold and Alford in 1948 recommended cutting down on the great saphenous vein and introducing polyethylene tube by this route into the inferior vena cava. The authors have not had any experience with this method. One objection to this method is the difficulty of keeping the operative field clean so near the perineum.

Weiner and Waxler in 1946 suggested that exchange transfusions can be readily accomplished by injecting blood through a cut-down of the superficial saphenous vein and blood withdrawn simultaneously from the radial artery which has been exposed and cut. Cut-downs on the saphenous vein are a more or less simple procedure and are done frequently by most people interested in pediatrics. The location of the radial artery may be more difficult particularly when one remembers that the ulnar and median nerves are located close by. When in doubt, if one will cut the suspected artery lengthwise no harm can occur if the nerve is accidentally cut in this manner. If bleeding occurs, one has located the artery. Before the bleeding is begun one should be sure that the prompt introduction of blood through the other

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cut-down can be accomplished.

The disadvantages of this technique are two skin wounds, one of which is an artery which generally must be sacrificed. No difficulty with the circulation to the hand has been experienced by the authors although the possibility is always anticipated. The method of continuous substitution is not as efficient as intermittent substitution and, therefore, larger quantities of blood must be exchanged.

If the baby is very anemic, blood should first be injected and the introduction of blood maintained at about 50-75 cc. ahead of the withdrawal. If there is any question of the baby being near cardiac failure, about the same amount of blood should first be withdrawn and this relationship maintained until the baby is out of cardiac failure. Once the procedure is going smoothly, a fairly rapid exchange can be accomplished.

Exchange transfusions are most successfully carried out by a trained, well equipped team. When adequate facilities for such treatment are not available locally and preparation cannot be made for delivery of the infant elsewhere, simple transfusion is usually performed; however, this will only be effective for milder forms of the disease.

The treatment of infants with hemolytic disease due to iso-immunization against the rarer blood group antigens will require the help of a blood group research laboratory so that suitable blood can be procured.

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1805 Monument Avenue.

"Cancer Cure" Found to Be Only Cough Medicine.

The American Medical Association's Bureau of Investigation reported recently that the only "pharmacologically active" ingredient in the so-called Hoxsey "cancer tonic" is a drug used mainly in cough medicine.

The bureau observed in the June 12th Journal of the American Medical Association that it sees no reason for the A.M.A. to further investigate the remedy. It points out that the federal government has obtained an injunction against shipment of the material in interstate commerce as a cancer medicine.

Any person with "a modicum of knowledge" of drugs knows that the medicine "is without any therapeutic merit in the treatment of cancer."

"Any such person who would seriously contend that scientific medicine is under any obligation to investigate such a mixture or its promoter is either stupid or dishonest.

"'There is indication that certain persons, including a Pennsylvania state senator and several physicians, magazine editors, and newspaper editors, have sought to create in the minds of the public an idea that organized medicine, particularly the American Medical Association, will not give Mr. [Harry] Hoxsey an opportunity to demonstrate his claimed cancer cure before the world, because it refuses to send representatives to Dallas, Texas, to investigate.

"It is fair to observe that the American Medical Association or any other association or individual has no need to go beyond the Hoxsey label to be convinced," the bureau stated.

"Under the circumstances, the whole picture would be extremely ludicrous except for the appeal to the credulous and unreasoning, which can conceivably result in unnecessary injury, damage, and death to many persons, not from an overdose of the Hoxsey tonic, but by reason of their relying on it instead of on proper, established procedures until their condition has progressed so far that they cannot be cured."

TRICHOBEZOAR—A Case Report

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Probably the best known of the rarer pathological entities in medicine are the bezoars. Every medical student knows what they look like. Yet, bezoars are relatively rare.

In 1939, DeBakey and Ochsner[2] reviewed the entire world literature on the subject and found only 303 reported cases. They added 8 cases from their own clinic, bringing the total to 311 cases. In 1950 Tondreau and Kirklin[9] again reviewed the literature and added 23 cases from the files of Mayo Clinic. They stated that there has been a total of about 400 reported cases. Since that time, sporadic cases have been reported[5,6]. There has not been a reported case in the *Virginia Medical Monthly* in the past fifteen years. Feldman[4] states that "in over 30,000 gastro-intestinal roentgen studies, not a single instance of this condition was observed".

The bezoars have been divided into five main groups. Trichobezoars are composed of hair of varying length, matted together. Phytobezoars are composed of vegetable fibers and matter. The persimmon ball is probably the most common of this group and is caused by eating the unripe fruit of Diospyros virginiana, the wild persimmon. Trichophytobezoars are combinations of the two. Mineral bezoars are produced by the ingestion of such substances as mica, wood, and paraffin. The "shellac" bezoar[7] is produced by the ingestion of wood polishes, shellac and varnishes for their alcoholic content.

DeBakey and Ochsner found their 311 cases to be divided as follows:

Trichobezoars	172 (55.3%)
Phytobezoars	126 (40.4%)
Persimmon	29.5%
Other foods	10.9%
Mineral & Shellac Bezoars	13 (4.3%)

Of these bezoars, 4.1% were classified as concretions.

The need for accurate and early diagnosis is apparent when one reviews the symptoms produced by trichobezoars, for they are the symptoms of many common gastro-intestinal disorders (see Fig. 1).

This case is being submitted with the permission of Maurice M. Fliess, M.D., Chief of Pediatric Section of the C. & O. Hospital, the physician in charge of the patient.

However, the complications of this entity are rather serious. Untreated, they lead to inanition, obstruction of pylorus or small intestine, and perforation. Levy and Smith[8] collected six instances of perforation of stomachs containing trichobezoars. The incidence of associated gastric ulcers has varied from a low of 9%, as reported by Levy and Smith,[8] to as high as 24.4%, as reported by DeBakey and Ochsner.[2] The overall mortality from exploratory gastrotomy and removal of the trichobezoar is approximately 4%, while the mortality in unoperated cases is about 75%.

FIG. 1

Upper abdominal mass	87.8%
Abdominal pain	70.2%
Nausea and vomiting	64.9%
Weakness and weight loss	38.1%
Constipation and diarrhea	32.0%

In analyzing a collected series, Fox and Stiles[5] felt that there was an underlying personality disorder manifested frequently by habitual actions such as nail biting or hair chewing. However, as shown by others, the personality disorder frequently cannot always be found, and there is a reported case of a woman who underwent five gastrotomies for the removal of recurrent hair balls.

The diagnosis of bezoar is relatively simple since the advent of roentgenology, especially fluoroscopic examination. Bezoars as small as 2 to 3 cms. in size have been reported. The X-ray findings are quite typical and have been described by various authors: Feldman,[4] Inlow,[7] Tondreau and Kirklin.[9] To quote DeBakey and Ochsner, "At present, with the most ubiquitous use of roentgenography, the lack of a correct pre-operative diagnosis is indicative of misfeance on the part of the physician".

The diagnosis is usually not suspected on a plain film of the abdomen. However, upon swallowing a barium mixture, a space filling defect is noted within the stomach. This mass usually can be displaced within the stomach. The barium is seen to flow in channels between the surface of the mass and the stomach wall. The most characteristic picture is seen after most of the barium has left the stomach.

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The barium can then be seen to occupy the small spaces between the hair.

Our interest in this subject was stimulated by a recent case of a seventeen month old Negro female, admitted to the Pediatric Service of the Chesapeake and Ohio Hospital. The little girl had had intermittent episodes of nausea, vomiting and abdominal pain for several months. She had been slow to gain weight. Physical examination revealed a small, poorly nourished child with short, kinky hair and patches of alopecia.

The laboratory findings demonstrated only a slight anemia HBG 10 gms. RBC 3,950,000), and a slight leukocytosis of 12,950 with 69% lymphocytes.

Radiological examination was not fully satisfactory as the child would not stand erect. The examination was performed in the recumbent position. On swallowing, barium was seen to flow around an intraluminal mass which, on palpation, did not appear to be a part of the stomach although it occupied most of the stomach (Fig. 2). With palpation,

Fig. 2. AP Projection of stomach after first swallow of barium mixture.

barium could be seen to move in channels about this mass. There was an initial delay in gastric emptying. However, when the duodenum was visualized, an extension of the mass was seen in the first portion of the duodenum (Fig. 3). A film taken approximately twenty-four hours after ingestion shows the mottled pattern of barium in the inter-

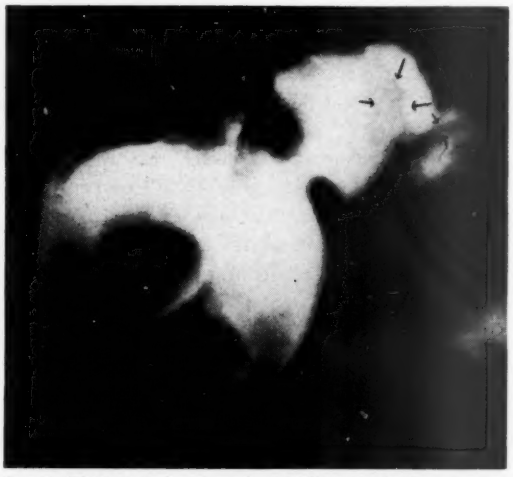

Fig. 3. Right Anterior Recumbent Oblique Projection showing duodenal bulb and part of the arc. A filling defect can be faintly made out.

spaces of the hair (Fig. 4).

On February 1, 1954, a large trichobezoar was

Fig. 4. 24 hr. film showing mottled pattern of barium in stomach.

removed at operation.

The specimen was a solid, cylinder shaped mass with tapered ends, measuring 8 cms., in length and 3.5 cms. in diameter. It was roughly the shape of a stomach and there was an extension from the distal end which assumed the shape of the first portion of the duodenum. The mass had a fecal odor, was black, and composed of matted hair, string and bits of cellophane (Fig. 5).

Fig. 5. Photograph of the gross specimen removed by surgery.

Summary

A case of trichobezoar has been reported with a short review of the relative frequency and the radiological findings for establishing a pre-operative diagnosis.

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T.B. and the General Practitioner.

It seems apparent that the general practitioner is going to be involved in the actual treatment of the tuberculosis patient to a much greater extent than he has in the recent past and fewer patients will be treated by specialists in chest diseases. Another factor acting in the same direction is the relatively shorter time that the average patient will spend in a hospital and the fact that such hospitalization is less likely to be in a remote institution. The family physician, therefore, will be less likely to lose supervision of his patient. This trend requires a change in the nature and emphasis of postgraduate medical conferences and courses of instruction, which must be directed more toward the general practitioner. James E. Perkins, M.D., NTA Bulletin, May, 1954.

Long-Acting Penicillin.

Tests on patients with infections from burns, compound fractures and surgery show one shot of a new long-acting penicillin can replace mutiple injections of penicillin.

Dr. John R. Hankins and George H. Yeager, University Hospital department of surgery, Baltimore, said the one-shot treatment controlled infection in all 46 patients tested, more of whom would ordinarily have required several doses of other pencillin types.

Benzathine penicillin G has already been found useful for treating infections accompanying rheumatic fever, for children with streptococcic infections, and for gonorrhea, the physicians said in the August 7th Journal of the American Medical Association.

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CLINICOPATHOLOGICAL CONFERENCES
of
The Medical College of Virginia Hospital

Prepared and Edited by
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WM. R. KAY, M.D.**

CASE #102

A 9 month old white male infant was first admitted to the Medical College of Virginia Hospital on March 20, 1952. He had been thought to have had more than the usual number of colds during the winter, but these were not associated with cough or croup. For about one month the parents had noted that the child made a soft grunting noise on expiration. The grunt would disappear when the child was asleep and often was not noticeable when the child was occupied with toys, etc. There was no history of fever, cough, or other symptoms.

The past history was not remarkable. His birth weight was 6 lbs., 13 oz. He was breast fed for four weeks and then put on an evaporated milk formula. Orange juice and percomorphum were begun at three weeks with other foods at the usual ages. He teethed at six months, sat up at six months, and was pulling up at the time of admission. There had been no recent exposure to infectious diseases. The family history was negative.

Physical Examination: Temperature 99.6. Pulse 120. Respiration 26. Weight 16 lbs., 13 oz. The patient was well developed and well nourished and in no apparent distress. The fontanelles were open, flat, and of normal size. Eyes, ears, nose, and throat were essentially negative. There were small bilateral cervical nodes. The lungs were clear to percussion and the chest moved normally. There were a few moist rales in both bases posteriorly. The heart sounds were of good quality. The rhythm was regular and there were no murmurs or thrills. The abdomen was negative. The genitalia were normal and no abnormalities were noted in the extremities.

X-ray and fluoroscopy of the chest showed marked enlargement of the heart with a large left auricle which extended backward beyond the vertebral column. The CT ratio was 70%. WBC 12,250 with 99% lymphocytes. A blood smear was reported as looking "more like a reaction than a blood dyscrasia". The urine was negative. An electrocardiagram showed a rate of 165 with a regular rhythm, a PR interval of .10 and a QS interval of .06. ST and T changes suggested left ventricular strain.

During this hospital stay the temperature ranged from 98 to 100. The patient was discharged after three days with no change in his condition.

The patient was again admitted on April 19, 1952, as an emergency. No interval history is recorded except that the parents had noticed that the baby's lips were blue during the past week. Examination showed a temperature of 102, respiration 76. Breathing was labored, but no cyanosis was noted. No murmurs were noted. The liver was palpable 4 fingers breadth below the costal margin and the spleen was also easily palpable. An electrocardiagram at this time showed marked sinus tachycardia with a left axis shift and x-rays again showed cardiac enlargement with the trachea pushed to the right.

Laboratory Data: Hemoglobin 11.9 grams, WBC 18,850 with 36 polys., 61 lymphs., and 3 moncs. It was felt that the patient was probably in congestive heart failure and he was given 0.4 mgm. of Cedilanid intravencusly. He did not respond, however, and expired several minutes later. An autopsy was obtained.

CLINICAL DISCUSSION BY DR. GAYLE G. ARNOLD*

In the first two paragraphs we have all that is available as to the present illness, past history and family history on this baby. "He had been thought to have had more than the usual number of colds during the winter". Very frequently a story such as this is due to the fact that there are several school age siblings who bring home to the infant every two or three weeks a new respiratory infection acquired at school. We do not have available any note as to whether any specific antibiotic or chemotherapy was ever needed, but I believe it is fair to assume these were mild colds, since it is stated that there was no cough or croup. Pharyngeal, tonsillar, or otic infec-

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tions are very common complications of a cold in this age group.

The actual present illness began in February, when it was noted that the baby made a soft grunting noise on expiration, but this was intermittent and was less noticeable when he was occupied with toys, or when he was asleep. Classically, grunting expirations are associated with respiratory embarrassment and very commonly indicate a pneumonic process. There is no fever or cough, however, and the respiratory embarrassment must be of a different sort in this baby.

"The past history was not remarkable." To this statement I would like to add that it is also not helpful to me. I must consider the growth and development, feeding history and family history as negative.

At this time the baby was admitted to MCV for a three-day period. The original physical reveals a normal temperature and slightly rapid pulse and respirations. The weight of 16 pounds 13 ounces at first seems adequate for a 9 month old child, and the casual rules of doubling the birth weight by 5-6 months has been met. However, I do feel that a weight of 16-13 at 9 months is below what one might expect in over 50% of children, and whether or not this is significant in this case would depend on hereditarily determined stature and medical evaluation. It would be much more helpful to know monthly weights and lengths, to see if with the present illness there were an abrupt change toward slowed growth.

The baby is described, however, as well developed and well nourished. Examination of the head, eyes, ears, nose and throat contributes only small bilateral cervical nodes. These are very common in infants with slight subcutaneous tissues, and with a history of frequent colds, I cannot become very excited about them. "The lungs were clear to percussion and the chest moved normally. There were a few moist rales in both bases posteriorly." We will return to this finding. The heart sounds were of good quality. The rhythm was regular and there were no murmurs or thrills. The abdomen was negative. The genitalia and extremities were normal.

Physical examination aids us very little in accounting for the symptoms listed in the chief complaint, except that moist rales were heard at the bases, bilaterally, and it is encouraging to elicit one positive physical finding in the system in which we are looking for pathology, on the basis of the presenting complaints.

Laboratory findings we hope will be more helpful. The white count was 12,250, of which 99% were lymphocytes, and the hematological study of the smear was reported as looking "more like a reaction than a blood dyscrasia." We are not aided by a hemoglobin determination, or red count, on this admission, but a urinalysis was negative.

X-ray and fluoroscopy of the chest certainly show an enlarged heart. The electrocardiogram demonstrates a sinus tachycardia, of regular rhythm, with a PR interval of 0.10 and a QRS time of 0.06. ST and T changes suggested left ventricular strain. The upper normal limit for the PR at this heart rate is about .135 and the QRS is normal. The ST and T changes are not described, but I assume they consist of depressed ST in I, with T inverted or low and elevated ST in lead III, with a leftward deviation of the QRS complex.

The EKG is therefore in complete accord with the x-ray and fluorscopic findings.

His course in the hospital was short, uneventful and within three days, he was discharged unimproved. Whether or not any treatment was instituted is nct mentioned, but I believe I may assume none was carried out.

Four weeks later, the child was admitted as an emergency, with an interval note that the parents had noted the baby's lips to be blue during the past week. He now had a fever of 102°, with extremely rapid respirations, with labored breathing. No cyanosis was noted, but could have been present, depending on the adequacy of the light at the time of examination. Still no murmurs were heard, but the liver was down 4 finger breadths and the spleen was easily felt. The EKG was similar to the previous admission, and x-rays showed progressive cardiac enlargement. We now are given a hemoglobin of 11.9 Gm., 18,850 white blood cells, 36% polymorphonuclears, 61% lymphocytes, 3% monocytes. The baby was given 0.4 mg. Cedilanid IV, but he died several minutes later.

In short summary, then, we have for diagnosis an infant who did well for 8 months, then showed grunting expirations, and in the hospital was found to have a very enlarged heart, with EKG evidence

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of strain, went home, and a month later was readmitted as an emergency, showing signs and symptoms of progressive heart failure, and he died rather promptly.

Our problem seems to be disease of the cardiovascular-respiratory systems entirely, and the question for immediate consideration is: Is the disease of congenital or acquired variety?

In a recent study in Toronto children this statement is made—"From birth to 5 years of age, heart disease in children is almost always congenital in origin." Davison states: "Under the age of 3 years the congenital variety is 100 times as frequent as the acquired." Going with the odds for the moment, what evidence is present for congenital heart diseases? First, the age of the patient, 8 months, when symptoms began, would be in favor of a congenital defect. Second, after a three day hospitalization, the baby was discharged home with no particular therapy. I imagine the parents were told: "The baby has a heart defect that he was born with, the heart is enlarged, and he is too young for us to make a definite diagnosis or consider whether any surgical relief can be contemplated."

If a congenital defect is present, what sort are we confined to, with the evidence before us? It must be of (1) the non-cyanotic group, i.e., Septa intact; ductus arteriosus and foramen ovale closed, no admixture of arterial and venous blood and with cyanosis only in the presence of heart failure. There are no murmurs recorded on any physical examination made, and the one hemoglobin determination we have is 11.9 Gms., and does not make one think of even a small arterio-venous shunt (unless compensated by a patent ductus.) Without murmurs to substantiate any of these, we can only conjecture. These findings would tend to rule out coarction also since 19 out of 20 of these will have cyanosis and usually show marked right axis deviation. There is no note as to femoral pulses or blood pressure.

One species of congenital cardiac malformation which is rare deserves our careful consideration. This is endocardial sclerosis. This lesion has been called fetal endocarditis in the past, and the pathogenesis is controversial. As far as I know, an ante mortem diagnosis has never been made. The history in this infant is certainly compatible with endocardial sclerosis, since they show sudden death, with mild or no cyanosis, x-ray evidence of an enlarged heart and occasionally nondescript murmurs are present.

If the lesion is congenital as the odds favor, and on the basis of all the negative data we are given, I would think this condition is a good possibility.

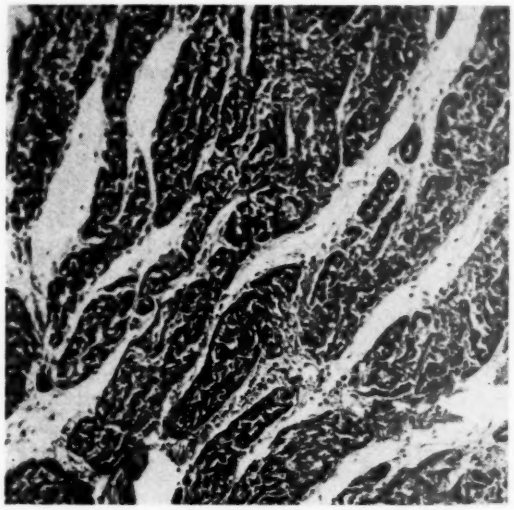

Fig. 1.—Section of the myocardium showing infiltration of round cells.

In clinico-pathological conferences, it is the universal experience not to neglect the one in a hundred possibilities, or the "almost never" conditions. Acquired heart disease in a nine month old child would certainly fall into this grouping.

Diffuse hypertrophy and dilatation of the heart may be secondary to longstanding anemia, syphilis, pertussis, beriberi, pneumonia, bronchitis, diphtheria, von Gierkes disease of the heart, poliomyelitis, and other septic or viral diseases, and may be a nonspecific reaction. It is here that I would accent the lymphocytosis and neutropenia found on the first admission, and it might militate for a viral type of infectious process, at that time or earlier. A number of labels, such as Fiedler's myocarditis, idiopathic myocarditis, and interstitial myocarditis have been used to describe this pathological process. The clinical picture is one of progressive myocardial failure, *unassociated with the usual causes of myocardial damage.* The outstanding symptoms are tachycardia, cardiac enlargement, and often increasing cyanosis. The EKG may reveal changes in the T wave. The course of the disease ordinarily is rapidly and progressively downhill and death may occur suddenly

and unexpectedly. Here again, the diagnosis usually is a pathological one, but there has been a recent increase in the percentage of autopsies which show some myocardial changes. A respiratory infection immediately before the onset of symptoms or weeks before onset is described frequently.

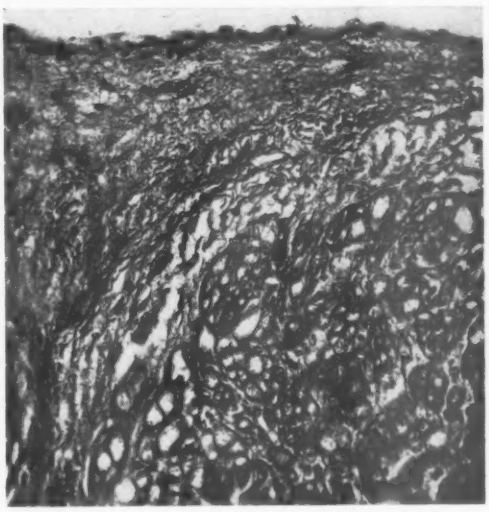

Fig. 2.—Section of heart showing fibrosis of endocardium and vacuolization in subendocardial layer.

I believe that our young patient had such an interstitial myocarditis, following one of his "more frequent" respiratory infections. Within the last week of life, I believe he contracted pneumonia terminally along with progressive cardiac decompensation. Very frequently there is an interstitial pneumonia as a concommitant finding with the myocarditis but his may have been of the terminal type. The leukocytosis, with the at least increasing polymorphonuclears is quite compatible with such an assumption.

In summary then, my diagnosis rests between two disease processes, both rare, both diagnosed by the pathologist after autopsy, both untreatable, one probably congenital: endocardial sclerosis, and one acquired: interstitial myocarditis. I believe I must favor the latter, with a terminal pneumonic process.

Dr. Arnold's Diagnosis: Interstitial Myocarditis
Anatomical Diagnosis: Fiedler's Myocarditis

Pathological Discussion by
Dr. Gordon Hennigar

The body was that of a well developed and well nourished 10 month old white male infant. The skin appeared normal. There was no lymphadenopathy. The abdomen was not distended and the liver was easily palpable 5 cm. below the right costal margin. No abnormalities were noted in the extremities. There was 125 cc. of straw colored fluid in the right pleural cavity and 50 cc. in the left pleural cavity. The pericardial cavity contained 400 cc. of similar fluid.

The heart was enlarged and weighed 150 gms. (normal 39 gms.) The left ventricle was markedly dilated and hypertrophied with flattened densely scarred endocardium. The right ventricle was slightly hypertrophied and the right ventricular cavity was encroached upon by the hypertrophied and dilated interventricular septum. The valves appeared normal.

On miscroscopic examination there were focal areas of lymphocytic infiltration in the myocardium, endocardial fibrosis of the left ventricle, and vacuolization of muscle fibers in the subendocardial layer of the left ventricle. Best's carmine stain revealed the vacuoles to contain glycogen.

The lungs revealed some compression atelectasis and were slightly edematous. Microscopically the lungs were the seat of minimal interstitial bronchopneumonia.

The liver weighed 350 gms. (normal 274) and appeared congested. Microscopically there was mild centrilobular atrophy and minimal fatty infiltration.

The probable cause of death was ventricular fibrillation following cardiac decompensation.

Fiedler, in 1899, described isolated myocarditis in man and since then this lesion has been recorded under a variety of names: Fiedler's myocarditis, myocarditis of unknown etiology, allergic, isolated, primary, interstitial, circumscribed, diffuse, and idiopathic myocarditis. The clinical picture is usually one of progressive myocardial failure, unassociated with the usual causes of myocardial damage. The outstanding manifestations are tachycardia out of proportion to the temperature, respiratory difficulty, cardiac enlargement and often increasing cyanosis. The electrocardiogram may reveal T wave changes. The course of the disease ordinarily is rapid and progressively downhill. Death is frequently sudden and unexpected.

The usual pathologic findings are a dilated and hypertrophied heart with associated findings of congestive failure. The myocardium usually exhibits

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diffuse and nonspecific inflammatory changes. Recently some involvement of endocardium and epicardium, have also been recognized. Pericardial effusion is rare. An interstitial type of pneumonitis has occasionally been described in association with this type of myocarditis and the initial manifestations of this condition are not infrequently those of an upper respiratory infection.

The etiology of this disease remains obscure. The myocarditis associated with various infectious diseases, such as diptheria, pneumonia, rickettsial infections, typhoid, and meningococcal infections, is well known. Also, a nonspecific myocarditis has occasionally been reported in association with tonsillitis, nasopharyngitis, acute and subacute glomerulonephritis, and a multitude of other infections. Myocarditis occurs frequently in acute poliomyelitis and has been reported in other virus diseases, including epidemic encephalitis, mumps, and influenza. Occasionally infectious mononucleosis is associated with a myocarditis. Deficiencies of vitamins B and E and of potassium have been shown experimentally to cause myocarditis.

Various other agents have been implicated in the etiology of the remaining cases of nonspecific myocarditis, usually called Fiedler's myocarditis. Some viral agent has frequently been suggested. Helwig and Schmidt* isolated a virus from the heart of an anthropoid ape and were able to reproduce myocarditis in guinea pigs, and myocarditis and encephalitis in mice and hamsters. Hypersensitivity has also been shown experimentally to produce similar myocardial lesions and has occasionally been implicated clinically.

ANATOMICAL DIAGNOSIS:

Fiedler's myocarditis

Generalized venous congestion

Minimal fatty infiltration of liver

*Helwig, F. C., and Schmidt, E. C. H., Jr.: A Filter Passing Agent Producing Interstitial Myocarditis in Anthropoids Apes and Small Animals. Science **102**: 31-33, July, 1945.

Histamine Relieves Pain.

The body chemical that makes hay fever patients suffer can bring relief from disabling leg pains to patients with blood vessel diseases. Dr. Isidor Mufson reported in the August 28 Journal of the American Medical Association on infusions of histamine for patients with diseases of the peripheral blood vessels (those near the skin). The infusions helped many patients to walk again and even prevented amputation in some severe cases.

Diseases resulting in closure of the vessels, such as arteriosclerosis, have become more important as causes of death because they occur with advancing age and because our life span has been increased. Insufficient circulation in those vessels is "rarely cured by removing the cause" but frequently can be helped by expanding the nearby vessels. Histamine, acting as a dilator, also may bring about permanent structural changes which prolong the successful effect of the treatment. Histamine is a natural body product, and its unusual concentration in the blood stream is what causes the swollen nose membranes and tearful eyes of the hay fever sufferer. It is too strong to be injected into the veins in concentrated form, but when infused, or allowed to flow by gravity into an artery, it is "safe" and "powerful."

Symptoms of peripheral blood vessel diseases include reduced tolerance to walking, and sleep-preventing pain when the patient is lying down. The pain can be relieved only by standing. Dr. Mufson said that of 150 patients with foot and leg pain, 36 per cent were able to walk up to seven blocks after treatment with histamine. Fifty-two per cent could walk from seven blocks to an unlimited distance. Of this last group, 40 per cent remained improved for as long as two to seven years after treatment. In another group of 41 patients treated and reported by other physicians, 70 per cent walked better after histamine infusions. 23 patients, so disabled that amputation was being considered, returned to normal routines. Only six severe cases required amputation. Many of this whole group had gangrene. The histamine infusions plus antibiotics helped to clear up infections among the gangrenous patients.

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MEDICO-LEGAL NOTES

The Practitioner's Role in the Medical Examiner System*

Seven years have passed since the adoption of the Medical Examiner System in Virginia. During those seven years our system has achieved nation-wide recognition and has been studied by many other states interested in establishing a similar system.

What measure of success the Medical Examiner System in Virginia has achieved is due primarily to the key man in the System—the local medical examiner. That concept has been the keystone of the structure and operation of the System in Virginia from its inception. No public agency established for the inquiry into certain types of death can succeed without alert, well trained local medical examiners to investigate the cases reported to them.

This fundamental concept of the Medical Examiner System can be extended one step further to include the practicing physicians in a state because a great number of the cases investigated each year are reported to the local medical examiner by physicians. Fortunately, in Virginia the Medical Examiner System has been enthusiastically received thoroughout the State by the medical profession and they have cooperated to the fullest in reporting cases as required by law. This recognition of reportable cases by the practicing physician is vital to the continued success of the Medical Examiner System.

There does occur, however, the occasional case in which, because of a number of reasons, a death is not properly reported and only reaches the attention of the Office of the Chief Medical Examiner when the death certificate is received by the State Bureau of Vital Statistics and that agency refers the certificate for investigation.

Since the busy practicing physician may have forgotten some of the deaths required by law to be reported it might be well at this time to review them and comment on some of the problems that arise from time to time.

Deaths which must be reported are those unattended by a physician, those occurring suddenly when in apparent health, all violent deaths, suspicious deaths, unusual deaths, deaths in prison or jail, and stillbirths attended by a mid-wife.

Unattended natural deaths include those without obvious or probable cause, those unattended by a physician at any time, and those unattended by a physician during the terminal illness, especially if such illness appears unrelated to a disease previously diagnosed and treated.

Sudden deaths include those which are instantaneous without obvious cause, those following an unexplained syncope or coma, and those following an unexplained rapidly fatal illness.

Suspicious deaths are those suspected of having resulted from accident, suicide or homicide where the circumstances are not clear cut.

Violent or unnatural deaths are those due to accident, suicide or homicide resulting from any physical, chemical, electrical, thermal or related means.

The practicing physician is most likely to encounter deaths, classified as unattended by a physician, sudden when in apparent health and certain suspicious deaths. In the usual case where death is due to accident, suicide or homicide the case is reported to the medical examiner by the police, funeral home or others, so the physician who might have been called during the emergency generally has no occasion to notify the medical examiner. There are certain cases, however, where the practicing physician is the only one who is in a position to judge whether or not the case should be reported to the medical examiner and if he does not do so an adequate medico-legal investigation is forever after made impossible.

Probably the most common type of case in which the attending physician has forgotten to call the medical examiner is where death has occurred weeks, months or years following an accident. Where the death can reasonably be attributed to the accident, no matter how long the interval between injury and death, the case must be reported to the medical examiner for he is the only one who can issue a valid death certificate. For example, if a person received a transection of the spine with paraplegia and two years later dies of septicemia due to infected decubitus ulcers, the death must be reported to the medical examiner because the death was related to the original injury. However, should the same bedridden individual die following the typical symptoms of a cerebro-vascular accident and a history of

*Contributed by: Harold L. Beddoe, M.D., Assistant Chief Medical Examiner, Office of the Chief Medical Examiner, Richmond, Virginia.

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hypertension, the death could not reasonably be attributed to the accident and therefore would not be a case for the medical examiner.

Another common type of case is that in which the physician is treating the patient for some relatively benign condition and the patient dies in his sleep or drops dead while at work. Unless his death is related to the condition being treated by the physician the death must be reported to the local medical examiner.

The family physician is very often the first one called in cases of sudden death while in apparent health. The physician may sign the death certificate without notifying the medical examiner because he knows the family well, or he may believe that a medico-legal investigation is not required or he may be satisfied from the story provided by the family that no suspicious circumstances exist.

These cases are of public interest, however, and should be reported to the medical examiner. Not infrequently an autopsy will reveal that death in these cases was due to an unsuspected overwhelming contagious disease, or some industrial public health hazard may be discovered. It is of vital interest in such cases to know the cause of death because the health of others may be endangered. Once the etiology is discovered the proper safeguards may be undertaken.

The physician should never hesitate to notify the local medical examiner in any case where there is some doubt as to the nature of the death. He will thereby avoid any future possibility of a claim that he failed to notify the proper authorities and he places the responsibility for the decision upon the medical examiner whose duty it is to investigate such cases. The medical examiner is limited in his authority to those cases described above and, if his decision seems arbitrary in a given case, this must be borne in mind by the reporting physician since the protective cloak of the law covers the medical examiner only so long as he does not exceed his authority.

The medical examiner can only order autopsies in those cases legally within his jurisdiction and if the *public interest* would be served by such autopsy. An autopsy will not be authorized simply to settle some academic medical question, i.e., in a hypertensive individual whether death was due to a cerebro-vascular accident or acute coronary occlusion.

With all of the practicing physicians throughout the State on the alert to carefully weigh the circumstances of each death encountered there will result a greater protection of the public health, more accurate reporting of vital statistics, the equitable settlement of estates, insurance policies and Workmens Compensation claims and a minimum number of otherwise unsuspected deaths of a violent or unusual nature.

New Books.

The following are some of the new books recently received in the Tompkins-McCaw Library of the Medical College of Virginia. They are available to our readers under usual library rules.

Advances in genetics. Vol. 6, 1954.

American Medical Association—Fundamentals of anesthesia. 1954.

Army Medical Service Graduate School—Medical basic science notes. Vol. I, II, and III, 1950-53.

Bower and Pilant—Communicable diseases. 7th edition, 1953.

Burch—A primer of congestive heart failure. 1954.

Ciba Foundation—The chemical structure of proteins. 1954.

Collected papers of the Mayo Clinic and Mayo Foundation. 1954.

Craig, editor—Hormones in health and disease. 1954.

Critchley—The parietal lobes. 1953.

Dubuisson—Muscular contraction. 1954.

Fishbein, editor—Children for the childless. 1954.

Hosler—A manual on cardiac resuscitation. 1954.

Irons—The story of Rush Medical College. 1953.

Joseph and Zern—The emotional problems of children. 1954.

King—Psychomotor aspects of mental disease. 1954.

Michal-Smith, editor—Pediatric problems in clinical practice, 1954.

Oak Ridge National Laboratory—Physiological effects of radiation at the cellular level, 1952.

Ormsby and Montgomery—Diseases of the skin. 8th edition, 1954.

Progress in neurology and psychiatry. 1954.

Rietz and Pollard—Problems in organic chemistry. 1953.

World Health Organization and United Nations Educational, Scientific and Cultural Organization—World Medical periodicals, 1953.

MENTAL HEALTH

Joseph E. Barrett, M.D.
Commissioner, Department Mental Hygiene and Hospitals

Research in Mongolism*

Last December 1, 1953 the medical staff at this Hospital began a research project in an endeavor to secure some information as to the relationship of thyroid extract and also pituitary extract to monogolism. This study was initiated after a visit here by Dr. C. E. Benda, Director of Research at The Walter E. Fernald School, Waverly, Massachusetts. Through the generosity of a local family we secured Dr. Benda for a lecture clinic on October 19, 1953. Beside our local staff and affiliated departments, there were present members of the medical profession from the Lynchburg, Charlottesville and Danville areas.

Dr. Benda expressed a conviction that a number of mongoloids had shown improvement when given thyroid extract together with whole pituitary gland extract from growing animals. He indicated that the administration required a period of several years.

Our medical staff with the collaboration of Dr. Benda, set up the following project here: On December 1, 1953, sixteen mongoloids, most of whom were under three years of age, were started on the program on a research basis. X-rays of the bones, of the forearm, and of the AP and Lateral Skull were recorded. Psychological evaluations of each child were made.

Four were put on 1/4 grain thyroid extract alone, four on 1 grain of whole pituitary extract from calves alone, four on 1/4 grain thyroid extract together with 1 grain of whole pituitary extract from calves, and four as controls were put on no treatment. It is proposed to continue this regime for a long time with six months X-ray and psychological re-evaluations. A Pediatrician has been checking these children at monthly intervals.

The plan is to start other mongoloids on the pituitary and thyroid therapy a little later—probably at the end of the first six months research project with the first sixteen patients.

Mongolism, or mongoloid idiocy, is a common type of mental deficiency making up from 5 to 10 percent of all defectives. It may be classified in the group of toxic mental defect although little, if any, evidence exists about the nature of the toxic agents responsible for the disease. Mongolism is distinguished by a peculiar conglomeration of physical traits. The stature is stunted; the head is small with a flat occiput, the hair course and scanty. The facial traits resemble somewhat those of individuals of the mongol race. The palpebral fissures are small, almond-shaped and slanting; epicanthic folds are present; the face is flat; the nose is short with a depressed bridge; ears are small, rounded and show a simple pattern; the tongue is large and fissured, the lower jaw rounded. Limbs are short, hands and feet small, short and flabby. Across the palm of the hand there is a transverse straight line, and on the sole another straight line from the heel to the first interdigital space. The little finger of the hand is curved medially and one transverse crease is missing. A large cleft is seen between the big and the second toes. There is a generalized laxity of the ligaments allowing an abnormal hypermobility of the joints. Congenital anomalies of the heart are not uncommon. Sexual development is incomplete and, with extremely rare exceptions, mongols are sterile.

Many variations in the number and degree of these physical abnormalities can be observed from case to case, but usually, there are enough traits present in the individual case to make the diagnosis a matter of superficial inspection.

The disease can be recognized at birth. The physical symptoms are not progressive and usually there is no mental deterioration. The majority of patients have an I.Q. between 15 and 40 with the upper limit in the 50's. Mortality in young age from intercurrent infection is high.

The pathological lesions are scanty and of doubtful significance. The brain is smaller and the convolutional patterns are simpler than normal. Loss of nerve cells and scattered areas of destruction of nerve coverings (demyelination) and scar tissue (gliosis) are often found but whether these features are the expression of an essential pathological proc-

*Article prepared by Dr. W. I. Prichard, Superintendent, Lynchburg Training School and Hospital, Colony, Virginia.

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ess or the consequence of intercurrent infections to which mongols are particularly prone, is not clear.

The etiological factors responsible for the disease are little understood. It is maintained that the condition appears in the fetus before the third month of pregnancy as a consequence of a variety of toxic conditions inherent to the mother and associated with advanced age, or endocrine disorders or pathological lesions of the uterus, but no conclusive evidence has ever been offered in favor of any of these factors.

There is no specific treatment for the condition.

Excessive Oxygen Related to Eye Disease.

Excessive administration of oxygen to premature infants is believed directly related to the development of a serious eye disease which may result in blindness, it was reported in a recent Journal of the American Medical Association. The disease, called retrolental fibroplasia, may be controlled by severely limiting the concentration of oxygen given to premature infants, a restriction which does not appear harmful, in the opinion of Drs. Jonathan T. Lanman, Loren P. Guy, and Joseph Dancis, New York. "Retrolental fibroplasia was first recognized as a disease of premature infants in 1942; it is now first among the causes of blindness in children in the United States, and is the foremost problem other than death itself in the care of premature infants."

The doctors based their conclusions on a year-long study of 64 premature infants admitted to the Bellevue Hospital Premature Nursery. The babies weighed between two and four pounds at birth. Thirty-six of the infants were given a high concentration of oxygen in their incubators and 28 received a low concentration. In the groups receiving a high oxygen concentration there were eight cases of irreversible retrolental fibroplasia. Six of these infants are believed to have no useful vision, while two may have useful vision in one eye. In the groups of infants receiving a low oxygen concentration, oxygen was administered only when breathing difficulty occurred. Early reversible stages of the condition developed in 22 (61 per cent) of the infants receiving a high concentration of oxygen. Only two babies in the groups receiving a low concentration of oxygen showed early stages of the disease.

All groups of patients received identical incubator care, formulas and vitamin therapy. Twenty per cent of the groups receiving a high oxygen concentration died, compared with 30 per cent in the groups receiving low oxygen. However, five of the infants in the groups getting a low oxygen concentration died of causes not connected with oxygen therapy, thereby reducing the death rate to 20 per cent, also. The correlation between oxygen therapy and the development of the disease is uncertain. The condition may be caused by excessive oxygen damaging the developing retinal blood vessels and the nerve cells of the retina.

"In a comparison of liberal and restricted oxygen therapy in premature infants, irreversible retrolental fibroplasia appeared in infants in the group with high oxygen but not in the group with low oxygen. Reversible, vascular stage lesions occurred in both groups, but with nine times the frequency in the group with high oxygen concentrations. Excluding infants dying of recognized causes with no known relationship to oxygen therapy, the mortality rates in the groups with both high and low oxygen concentrations were the same.

"We believe that retrolental fibroplasia is directly related to the excessive administration of oxygen and can be controlled by severely limiting oxygen therapy to premature infants. Such restriction does not appear harmful."

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NOTES ON PULMONARY TUBERCULOSIS*

Modern Therapy (III)
Indications (B)

The Virginia State Health Department has requested that *all* cases of tuberculosis be reported, whether or not they are regarded as active. (See "What Is a Reportable Case", August Issue, Virginia Medical Monthly).

As previously described (see September Issue, Virginia Medical Monthly) *all* newly reported cases for whom formal treatment (systemic rest, drugs, etc.) is prescribed, are classified as *active*, by local health departments affiliated with the Virginia State Health Department. This is done on the seemingly well founded assumption that there would be no point in deliberately modifying the normal life pattern of a patient, or in subjecting him to drug therapy, except to combat a hazard to his life or health which is considered to exist because of the presence of tuberculosis.

On the other hand *all* newly reported cases, for whom treatment is *not* prescribed, with extremely rare exceptions, are categorically classified in Health Department Registers, as "apparently inactive", as are those who were originally classified as "active" but who achieve a status of "apparently inactive" by virtue of retrogression of their disease to a point where treatment is no longer prescribed.

The reason *newly* diagnosed cases are not classified in Health Department Registers as "inactive", even when no treatment is immediately indicated or prescribed, is because of the current diversity of standards employed, to say nothing of the actual absence of really dependable criteria, to determine eligibility for this classification, *definitely, at time of diagnosis* (there being invariably a *retroactive* time element involved).

Accordingly it would seem to be *far safer* and probably more sound, from a public health point of view, to consider these cases "inactive" only after they have been observed and periodically examined for a specified period following diagnosis. During this "probation period" the potentially "inactive" patient is classified as "apparently inactive". Upon completion of the probationary period, during which the patient has taken no formal treatment, and has shown no tangible evidence of reactivation, the case is certified and accordingly re-classified as "inactive"; his record is closed, i.e., the patient is removed from supervision of any kind by the health department.

The reason the previously "active" case, when no longer in need of treatment, is reclassified as "apparently inactive" instead of "inactive", is because during the terminal phase of treatment no one can be sure as to whether his apparent good health during that phase was due *in part* to treatment still being received, or whether it really was due *wholly* to his disease having become truly "inactive". It is felt, therefore, that this patient, also, should be observed and examined periodically, i.e, "tested under fire", *after* he has ceased to take formal treatment (after he has begun to lead a normal life), before being certified for closure as "inactive".

What specific bearing does "exercise" have on this classification?

Eventually, it is hoped, local health department registries will contain no "inactive" cases which have not, over a period of *at least* two years, met at least minimum stipulations for closure, during which the patient's exercise has been unrestricted, and he has suffered no clinical reactivation. During this period he is classified as "apparently inactive". Thus it will be seen that exercise is unrestricted (no formal rest is prescribed) in both the "apparently inactive" and the "inactive" classifications. Patients are regarded as "presumably non-communicable" and "non-communicable" respectively in these categories.

The active case on the other hand may require, in terms of systemic rest, anywhere from 24 hours a day flat in bed to 15 minutes on a couch after lunch each day. "Exercise" may consist of practically none, to working 8 hours a day in addition to leading a perfectly normal life in other respects, except for the fifteen minutes per day which the patient's

*Prepared by the Virginia State Health Department.

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physician may still consider necessary to combat an existing hazard to the patient's health or life by virtue of his tuberculosis.

What about drugs? Obviously if the patient is on specific antituberculosis drug therapy, he is classified as "active" whether *or not* his exercise status is stimultaneously restricted; he is taking specific or formal treatment for tuberculosis which *categorically* would make his case "active". Why would anybody take drugs for any disease except to combat an existing hazard to health or life sufficient to indicate need for their administration?

What about collapse therapy? Where the collapse measure is reversible, the patient again must be considered to have "active" tuberculosis by virtue of this fact alone, otherwise the collapse procedure would have been discontinued.

The key word throughout is *hazard;* when no hazard remains sufficient to justify a formally restricted exercise status, the prescription of drugs, or the continuation of a reversible collapse procedure, the patient is eligible for reclassification as "apparently inactive".

What about patients whose original (pre-illness) pattern of life has been permanently altered, deliberately, by virtue of their "having had" pulmonary tuberculosis? Some patients are advised by their physicians to acquire a new, physically (or otherwise) less exacting skill or occupation by which they may earn a living *following* their "recovery" from tuberculosis, with the thought in mind that this will reduce to a minimum any residual tendency the disease might have to reactivate or "relapse". When undertaken with this express purpose in mind, the differential in systemic rest obtained in the new job as compared with the old, might, *by stretching a point,* be considered as "treatment" prescribed to combat a residual hazard to health or life, caused by tuberculosis, i.e., treatment for subclinically active disease. This would of course go on *indefinitely* and the patient could *never* hope to become eligible for reclassification as "apparently inactive" as this term and concept have been described.

From a *practical* standpoint, however, this extreme, overly extended, "strained" application of the term "subclinical activity" clearly serves no useful purpose whatever in any phase of tuberculosis control, including patient management. Its employment in this sense can easily be deleted without detracting in the least from the extremely important role both the term and the concept can and should play, when employed as suggested.

Furthermore, it would actually be much more realistic to look upon any newly acquired less exacting occupation as being prescribed to compensate for an anticipated partial permanent disability *resulting from* tuberculosis (*following* recovery from both clinical and subclinical disease). It would then be this *partial permanent disability* which makes impossible safe return to former employment, just as with the loss of a leg. The same can be said for many other types of alterations of ex-tuberculous patients' previously conceived ideas of a normal life pattern *for them,* unrelated to occupation, when *prescribed on a permanent basis.*

This is not to be confused with systemic rest obtained through change in occupation prescribed or taken as a part of total systemic rest, or in lieu of other forms of systemic rest, for treatment of clinically or subclinically active tuberculosis; this latter treatment *also* may be prescribed upon a perennial basis, where the real objective, consciously or subconsciously, is "control" rather than "clinical cure".

Specific anti-tuberculosis drugs and modern surgery now available to supplement basic systemic rest, applied to new cases diagnosed earlier and earlier, should, of course, reduce tremendously, and before long virtually eliminate from the tuberculosis scene, the notoriously large group of unfortunate individuals who in the past (and at present) have had to take treatment of varying degree for *active* tuberculosis the balance of their lives, *or,* who were obliged to compensate in one way or another for a partial permanent disability resulting therefrom.

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PUBLIC HEALTH

Mack I. Shanholtz, M.D.
State Health Commissioner of Virginia

Veterinary Public Health

Throughout history man and animals have lived in close association. Man has derived food, clothing, transportation and companionship from his animal friends for many thousands of years. Today, the same story holds true and, in addition, we are supplied with medicines, serums and vaccines of animal derivation.

Although the animal has contributed significantly to medical research and the conquest of human disease, certain disadvantages are latent in this biological corporation. There are some 80 infectious diseases transmissible from animals to man. Placing animals in an unnatural and crowded environment, man has facilitated the concentration of disease producing organisms. Distance, as a factor in isolating susceptible hosts, has rapidly become ineffectual with modern modes of transportation. The exotic disease of yesterday may become all too familiar tomorrow. Because of all these factors, the (Public Health) Veterinarian has become a part of the public health organization.

The World Health Organization describes veterinary public health as "all the community efforts influencing and influenced by the veterinary medical arts and sciences applied to the prevention of disease, protection of life and promotion of the well-being and efficiency of man." While the practice of veterinary medicine has always contributed significantly to the control of many of man's infectious diseases, health departments have only recently incorporated broad veterinary public health programs into their organizations. Virginia is one of 22 states with a full time public health veterinarian in the State Health Department. His place and duties may be broken down into the following broad categories:

1. Development of programs to control and eradicate animal diseases transmissible to man.
2. Liaison with other departments of state government such as Agricultural and Wildlife regarding veterinary public health problems.
3. Consultation with other operational units in the health department, local governing bodies, voluntary agencies and the veterinary profession concerning veterinary public health problems.
4. Development of field and laboratory investigational projects of special animal disease problems.
5. Assistance in developing programs for inspecting foods of animal origin.

When we understand that animal members of our environment may actually contribute to the disease picture in the human family, we can proceed to methods and means for the control of specific conditions arising from animal sources. It is axiomatic that many of these diseases could be eliminated as a human health hazard if they could be stamped out in the animal population. As examples of such diseases we could list rabies, brucellosis, erysipeloid, trichinosis and psittacosis.

Rabies, in particular, lends itself well to public health control measures. We have now the tools at hand with which to stamp out this infection. A new live modified virus vaccine for dogs has been evolved by culturing a modified strain of the organism in chick embryo (Fleury strain). It has been shown to be safe, when properly used, and to impart immunity, in dogs, lasting up to 39 months. More than two and one-half million doses have been administered with no serious reactions except in one puppy and one cat. The puppy and cat developed what was termed "neurological disease," and died. These two isolated occurrences pale in significance when we think of the relatively large number of anaphylactic reactions occurring with the Semple vaccine. Coupling mass immunization of dogs, elimination of strays and the reduction of wildlife vectors with public education about this disease would eventually eliminate rabies as a serious problem in this state. For every rabid dog in a community, it has been estimated that 20 persons undergo the Pasteur treatment.

Psittacosis is becoming more and more of a problem. With the discovery of the disease in native birds (ornithosis), quarantine regulations on the psittacine family were relaxed. Although psittacine birds are most often involved where human infections are present, turkeys, chickens and pigeons have been incriminated. Atypical cases of pneumonia,

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upon serological diagnosis, have often proved to be psittacosis. A careful case history will often point to avian vectors. Young birds with psittacosis most commonly die but older birds which have survived an attack become carriers and periodically discharge the organism during relapses. Buying birds from a reputable dealer is the best protection and guarantee that the bird is healthy.

Brucellosis is the greatest of our problems both in numbers infected each year and in control methods. It has been estimated that 10,000 human cases occur annually in the United States although fewer are reported. Through the 15th of August, 1954, Virginia has had 27 cases of undulant fever reported. Most of these cases are among people who work with animals (farmers, meat packers, veterinarians). Tests run in various packing plants over the nation would indicate one third of the packing house workers have significant brucellosis blood titres. The most common strain of the organism found in man is B. suis. Perhaps one of the inconsistencies of control programs lies in the elaborate test programs run on cattle while swine are so often ignored. Of course, any of the three brucella strains may be present in a susceptible host without regard to species. The disease is rural and it is definitely an occupational hazard with certain groups. It often masquerades as other conditions. Control lies in eliminating the disease in livestock by testing, vaccinating and slaughtering of young animals. Carrying out of good milk sanitation ordinances prevents the extensive spread of Bang's disease.

There are many other diseases in Virginia's livestock of public health significance. Weils disease is more prevalent than before, mycotic skin conditions of the family cat may appear on the children; salmonellosis and Taenia saginata appear in the food; 20% of Americans have Trichinella larva in their muscles. The new and unusual "cat scratch fever" is not to be disregarded. All of these, and more, are problems for the veterinary public health program planner.

MONTHLY REPORT OF THE BUREAU OF COMMUNICABLE DISEASE CONTROL

	Aug. 1954	Aug. 1953	Jan.-Aug. 1954	Jan.-Aug. 1953
Brucellosis	9	10	30	38
Diphtheria	0	3	26	56
Hepatitis	161	202	2946	1649
Measles	209	145	23378	4627
Meningococcal Infections	4	7	77	145
Poliomyelitis	148	262	253	455
Rocky Mt. Spotted Fever	6	11	28	50
Streptococcal Infections (Incl. Scarlet Fever)	301	378	3564	4175
Tularemia	1	4	25	22
Typhoid Fever	5	6	35	34
Rabies in Animals	18	30	272	329

Nervous Stress.

That familiar urge to "get away from it all" should be succumbed to when it is a sign of stress according to an editorial in the July 10th Journal of the American Medical Association.

The editorial said stress implies "an inner conflict or a conflict against circumstances for which no immediate action is appropriate."

"As with other conditions, prevention, when possible, is better than cure. Removal of the cause is still the best treatment. After that, rest, a change of scene, and a change of interest are the most effective therapeutic measures." Continued stress may result in such diseases as duodenal ulcer, malignant hypertension and rheumatoid arthritis. It may play an important role in nervous fatigue, infection and intoxication.

The editorial reported on a study of combat stress during World War II and the Korean conflict. It showed that men who had been under almost constant artillery bambardment for five days with only 7 per cent casualties were far worse off than those who had withstood 18 hours of intense fighting in which the unit suffered 70 per cent casualties.

The study also showed an enormous difference in individual reaction to stress. It appears that some persons have the ability to withstand much more stress without breaking down.

But the editorial warned that "no one is immune from breakdown if the stress is severe enough and sufficiently prolonged."

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First Interstate Scientific Assembly

To the Members of The Medical Society of Virginia

Plans are nearly completed for the First Interstate Scientific Assembly being held at the Shoreham Hotel and the Sheraton-Park Hotel, Washington, D. C., October 31 through November 3, 1954. This Annual Meeting of The Medical Society of Virginia which is being held for the first time with the Medical Society of the District of Columbia has every indication of being the most outstanding ever held by either society.

We trust that by now you have made yourself familiar with the program and hope you have found it to your liking. Many well-known guest speakers, several of our distinguished colleagues from the District of Columbia and of course, as customary, many of our own members will appear on the Scientific Program. The Scientific Exhibit was carefully selected, as were the Medical Motion Pictures. We believe you will find everything to be diversified and constructive.

The many social events were planned with only your pleasure in mind. And we wish to remind you that this year there will be no speakers at the Annual Dinner. "Skitsophrensia"—A Medical Mèlange—will be presented following the dinner.

With Dr. Archer, who will always be remembered as one of our most distinguished Presidents, as a leader of the Assembly, every effort has been made to make this meeting a memorable one.

However, only your attendance can make it a success.

Cordially yours,

James W. Lowe

Co-Chairman, Committee on Arrangements,
First Interstate Scientific Assembly

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THE MEDICAL SOCIETY OF VIRGINIA REPORTS FOR THE 1954 ANNUAL MEETING

Executive Secretary-Treasurer

As fiscal year 1953-54 draws to a close, the administrative staff of The Medical Society of Virginia takes pride in reporting to the membership that the Society has never been on sounder ground financially, its membership has never been greater, and its activities have never been more varied and pronounced. Credit must go to an enterprising President and Council, and to the various committees, whose activities reflected an interest and sincerity of purpose which could result only in progressive accomplishment.

The mid-winter meeting of Council was held February 25, and complete minutes can be found in the April 1954 issue of the Virginia Medical Monthly.

Committees: Thirty-four committees (12 standing and 22 special committees) have done a very fine job in fulfilling their responsibilities, and the membership is urged to read carefully the committee reports found on the following pages. It is an absolute fact that a medical society is only as progressive as its committees, and the accomplishments of the past year are a direct result of committee effort. Fourteen committees utilized Society headquarters for meetings, and eighteen made use of other available services. Although this remains a disappointing number, some encouragement can be found in that it represents a slight increase over last year.

Component Societies: There remain 46 component societies to The Medical Society of Virginia. Two of these societies are comparatively inactive and a positive effort will be made during the coming year to assist them back to their former status.

Visits were made to seventeen meetings of component societies which is a gain over previous years. Only by this personal contact is it possible for the State Office to establish and maintain that close relationship with its members which is so necessary in any progressive organization.

Membership: The continuing drive to bring all eligible physicians into The Medical Society of Virginia is meeting with amazing and unexpected success. The magic figure of 2400 has been passed and the following statement tells the story in detail:

Members reported July 31, 1953			2,368
New Members	182		
Reinstated	6		
		188	
Deaths	57		
Resignations	25		
Dropped	23		
		105	
Increase			83
Total Membership as of August 31, 1954			2,451

American Medical Association Membership: During the first half of the year, a campaign was waged to bring about the reinstatement of many Society members who had been dropped from the A.M.A. as a result of the confusion surrounding 1950 A.M.A. membership dues. A ruling of the A.M.A. made it possible for those physicians to be reinstated if their 1954 dues were paid by July 1, and a goodly number took advantage of the offer.

A late check of the records reveals that 1918 members of The Medical Society of Virginia are members of the American Medical Association. This means, of course, that the Society is still authorized two delegates to the A.M.A.

Annual Meeting: The 1954 Annual Meeting, known as the First Interstate Scientific Assembly, is a joint affair with the Medical Society of the District of Columbia, and has posed a number of problems never before encountered by the staff. This historical event promises to be one of the finest meetings ever held in the East, and all credit must go to the joint committees on arrangement. These committees have worked untiringly to make the Assembly an outstanding success, and their work certainly deserves the plaudits of the membership.

The staff has worked with the Executive Committee of Council in making initial plans for the 1955 Annual Meeting, which will return to Richmond. Dates agreed upon are October 16-19, 1955.

Meetings and Conventions: The state office was represented at both sessions of the American Medical Association, two other national conferences, two meetings of state associations, and eleven special meetings of civic groups, etc.

Special Events: Two events of particular significance took place during the year, and the state office staff is indeed pleased to have been associated with both. A reception, given by the Society in honor of Dr. Walter B. Martin, was held in St. Louis during the Interim Session of the A.M.A. and was attended by approximately 350 officers of the A.M.A. and their guests.

A statewide conference on the problems of the medically indigent was presented in cooperation with the Virginia Council on Health and Medical Care and attracted national attention. The conference, first of its kind anywhere, was attended by over 300 representatives of medical and civic groups. A report of the conference can be found in the February issue of the Virginia Medical Monthly.

Selective Service: There was a noticeable increase in the work required for the State Voluntary Committee to Selective Service. After a brief respite occasioned by the end of hostilities in Korea, etc., the Armed Forces have again issued calls to replace a large number of physicians and dentists soon to be separated from service.

The work continues to require approximately 35-40 man hours per month.

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Woman's Auxiliary: Once again the Auxiliary made important contributions to Society progress. The program of the Annual Public Relations Conference was highlighted by an Auxiliary presentation on the importance of auxiliaries to component societies. This undoubtedly had much to do with the fact that two new component auxiliaries were organized during the year.

The Auxiliary also, for the second straight year, made it possible for an exhibit to be sponsored at the Atlantic Rural Exposition. Without Auxiliary assistance in supervising the exhibit, such an undertaking would not have been possible.

The state office saw continued evidence of the growing interest in Auxiliary affairs, and wishes to express appreciation of Auxiliary efforts in helping prepare for the First Interstate Scientific Assembly.

Virginia Council on Health and Medical Care: This organization has turned in another excellent performance, especially in the field of physician placement. In this connection, the state office has referred to the Virginia Council 61 inquiries from physicians interested in practicing in Virginia. A Council report reveals that 29 placements have been effected during the year.

Personnel: A severe blow was suffered by the Society with the loss of Miss Agnes V. Edwards, whose death occurred on May 22.

Mr. Edwin F. Smith, Jr. came with the Society on January 1 and has assumed the duties previously handled by Mr. Nash. The addition of Mr. Smith keeps the number of state office personnel at five, the same as reported last year. No additions are contemplated.

The staff wishes again to extend to the membership a most cordial invitation to visit the Society Headquarters at 1105 West Franklin Street, Richmond.

ROBERT I. HOWARD

Woman's Auxiliary

The Woman's Auxiliary to the Medical Society submits the following report:

Virginia reports 877 members for the year, an increase of 116 over last year. We have organized a new auxiliary in Wise County and will meet with the Tri-County Medical Society in Suffolk on September 28th with the hope of organizing another one.

Our program for the year has followed the National program, with special attention being given to Health Education in the County Auxiliary meetings.

Our most outstanding work in Public Relations was the presentation of a program showing the kind of work done by our organization and why it is good Public Relations. This was presented before The Medical Society of Virginia's annual state-wide Public Relations Meeting. The program was prepared by Mrs. Richard M. Reynolds, who is now the National Public Relations Chairman, participated in by six auxiliaries, and moderated by Mrs. Leo J. Schaeffer, our National President.

Our Auxiliaries have cooperated with schools and Parents and Teachers Associations, and with all health and welfare organizations, have supplied speakers where they were desired, have done much community service, and have entertained representatives of other organizations at Public Relations Meetings. We have maintained state and local memberships in the Virginia Council on Health and Medical Care, and have tried to further its program.

We have stressed Nurse Recruitment this year as a main objective. Eight scholarships are being given by County Auxiliaries, six of which are three year scholarships. We have worked especially on Future Nurses' Clubs, and now have seven, five of which were organized this year. Where it has not been possible to do other Nurse Recruitment, talks have been made to High School girls, particularly seniors, in at least twenty schools. Conducted tours of hospitals have been given. Parties and dances for student nurses have been held, and contributions toward the maintainance of nursing schools have been made.

As a member of the "Virginia Council of Legislative Chairmen of State Organizations" our Legislative Chairman attended the State Legislature regularly, kept careful watch over bills which concerned the medical group, and reported back to the counties. She reported, also, on National legislation.

Virginia maintains the Leigh-Hodges-Wright Memorial Fund, to which our Auxiliaries make contributions every year. This fund is for the use of any physician or his family who is in need of assistance for the treatment of tuberculosis. It has not been needed this year, and is being built up for the time when it may be needed. The Norfolk County Auxiliary also has a "Benevolent Fund" to be used for a physician or his family who may be in need of it. We also contribute to the "Jane Todd Crawford Memorial Fund" of the Auxiliary to the Southern Medical Association.

Our subscriptions to "Today's Health" have been increased this year to 220 4/12 credits for the year.

We have received excellent publicity throughout the state through the press, radio and television. Our page in the Virginia Medical Monthly has carried good accounts of our meetings throughout the state each month, and is being widely read by our members.

We have stressed the American Medical Education Foundation work. The State Auxiliary has contributed fifty dollars to this, and eight of our County Auxiliaries have contributed two hundred and forty dollars, a total for this year of two hundred and ninety dollars.

The County Auxiliaries have purchased two doctors' call boards for hospitals, given 150 Christmas presents to children's Community Clinic party, have collected, repaired and fitted shoes for needy children, in cooperation with city welfare workers, have maintained a Memorial Room in a hospital, this year reflooring, redecorating and refurnishing it. "Doctor's Day" has been observed with dinners for the doctors, dances, picnics, the presentation of flowers, and with services to the communities in honor of our doctors. The most outstanding of those was in

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Richmond, where sample drugs were collected from the doctors' offices, sorted out by druggists, and presented to charity hospitals. Last year the collection of drugs was estimated to be valued at $8000.00, and they were given to Sheltering Arms Hospital. For this the Richmond Auxiliary received the first award for the best and most original observance of Doctor's Day from the Woman's Auxiliary to Southern Medical Association at the convention in Atlanta last November. This year the drugs collected were valued at $13,300, and were divided between six charity hospitals.

The Virginia Auxiliary deeply appreciates the cooperation received from Dr. Vincent Archer, Mr. Robert I. Howard and his Staff, and from The Medical Society of Virginia for their assistance throughout the year, and wishes to take this opportunity to express sincerest thanks.

MARGARET P. HOWARD
(Mrs. Kalford W. Howard), *President*

Publication

During the past year the staff of the Virginia Medical Monthly suffered the loss of its editor, Dr. Marvin Pierce Rucker, who died on October 23, 1953. Even during his prolonged terminal illness Dr. Rucker continued actively as editor, in which capacity he had served so effectively since 1942.

Miss Agnes V. Edwards, managing editor of the Virginia Medical Monthly since 1919, died on May 22, 1954. Miss Edwards, the daughter of Dr. Landon B. Edwards, who started the Monthly as a private enterprise in 1874, had devoted her entire energies to the welfare of the Virginia Medical Monthly for many years. Her place has been taken by Miss Spencer Watkins, who had served as her assistant since 1929.

At the beginning of this year, following the death of Dr. Rucker, an editorial board was appointed by the President to assist the Publication Committee and newly appointed editor with the editorial duties and responsibilities.

The content of the Virginia Medical Monthly has remained essentially unchanged during the past year. Two additional monthly feature columns of considerable interest have been added. The column "Medicolegal Notes" has been prepared jointly by the Medical Examiner's office and Dr. Charles W. Whitmore of the University of Virginia. The column on "Pulmonary Tuberculosis" prepared monthly by the Virginia State Health Department aims at presenting the practical diagnostic and therapeutic features of pulmonary tuberculosis.

The circulation of the Virginia Medical Monthly at this time is 2843.

LEWIS H. BOSHER, JR., M.D., *Chairman*
WYNDHAM B. BLANTON, M.D.
LLOYD B. BURK, JR., M.D.

Scientific Exhibits

There have been two meetings of the Joint Committees for the Scientific meeting. The first meeting was held in February and the general policy of the Joint Committee was adopted.

The second meeting was held in May for the purpose of discussing various applications and deciding their acceptability. The meetings were well attended by both the Virginia and District of Columbia members. The Virginia members are indebted to the Washington members for their hospitality and friendliness which they have enjoyed. Both meetings were held at the Medical Society of the District of Columbia.

HUNTER B. FRISCHKORN, M.D., *Chairman*

Program

Inasmuch as the Annual Meeting is this year a joint affair with the Medical Society of the District of Columbia, your Committee has worked closely with a similar committee of the District Society in preparing the program.

The complete program was published in the September issue of the Virginia Medical Monthly.

BENJAMIN W. RAWLES, JR., M.D., *Chairman*
IRA L. HANCOCK, JR., M.D.
A. A. CREECY, M.D.

Post-Graduate Medical Education

The Committee on Post-Graduate Medical Education has had no meetings during the year. However, the work of the committee proceeded as in previous years, and was supervised by Dr. Kinloch Nelson.

A joint meeting for the Mid-Tidewater and Northern Neck Medical Societies was held in Tappahannock on April 14, 1954, and featured five speakers. Expenses were $250.00, of which the local societies contributed $37.50, leaving an expense to the committee of $212.50.

The committee stands ready to sponsor such scientific meetings whenever local physicians wish to avail themselves of this service.

Although the committee operated well within its budget of $1000.00, it recommends that the same appropriation be authorized for the coming year.

JAMES L. HAMNER, M.D., *Chairman*
JOHN T. T. HUNDLEY, M.D.
MACK I. SHANHOLTZ, M.D.
KINLOCH NELSON, M.D.
WILLIAM PARSON, M.D.
C. V. CIMMINO, M.D.

Ethics

There have been no matters referred to this committee which necessitated a meeting of the committee or any formal report.

M. H. HARRIS, M.D., *Chairman*
H. H. HURT, M.D.
H. S. DANIELS, M.D.

Grievance

During the past year, the Grievance Committee was requested to consider three cases that had been appealed from the component society.

Upon investigation, it was found that in one of the cases, the physician concerned was not a member of the State Society and this case was referred back to the com-

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ponent society. The other two cases were carefully considered by a majority of the committee.

In each of these cases a unanimous decision was reached and the component society and the physician were advised of the committee's action.

From the small number of cases referred to the State Society, it would appear that the local committees are doing a splendid job at the local level.

W. C. CAUDILL, M.D., *Chairman*

Judicial Committee

AMENDMENTS TO THE CONSTITUTION

The following amendments to the Constitution of the Society have been proposed and are now published in the official publication as required by Article XIII thereof:

ARTICLE IV—COMPOSITION OF THE SOCIETY

Delete the word "White" in the first line so that the first sentence shall read: "Physicians in Virginia, not practicing sectarian medicine, members of a component society, shall be eligible for active membership."

The purpose of this amendment is to authorize physicians other than those of the white race to become members of the Society.

ARTICLE VI—COUNCIL

Change the last sentence in the article to read as follows: "The Editor, the Speaker of the House of Delegates, and the State Health Commissioner, shall be ex-officio members of the Council."

ARTICLE VII—HOUSE OF DELEGATES

At the end of the present article add the following new sentence: "The Speaker of the House of Delegates shall be an ex-officio member and the presiding officer of the House of Delegates, but shall vote only in the case of a tie. He shall appoint all special committees whose duties are concerned primarily with the operation and functioning of the House of Delegates."

The purpose of these two amendments is to prescribe certain duties of a Speaker of the House of Delegates.

AMENDMENTS TO BY-LAWS

The following amendments to the By-Laws of the Society have been proposed in writing and will be presented to the House of Delegates for adoption or rejection at the next annual meeting.

ARTICLE V

Section 4. Strike out the word "President" in the first sentence and insert in lieu thereof "Speaker of the House of Delegates".

Section 5. Strike out the word "President" in the first sentence and insert in lieu thereof "Speaker".

ARTICLE VI

Section 1. (a) At the end of the first sentence strike out the word "President" and insert in lieu thereof "Speaker".

(b) Strike out the word "president" in the last sentence and insert in lieu thereof "Speaker".

Section 4. At the end of the section add the following: "The House of Delegates shall elect a speaker of the House of Delegates to take office at the next annual meeting and to serve for a term of two years. At each second annual meeting thereafter a Speaker of the House of Delegates shall be elected for a two year term. In the event of a vacancy occurring in the office of Speaker the President shall appoint a Speaker to serve through the next annual meeting, at which meeting the House of Delegates shall elect a Speaker for the unexpired term or for a new term as the case may be."

ARTICLE VII

Section 2. (a) In the first sentence after the word "Society", strike out the word "President" and insert in lieu thereof "a member".

(b) Change the second sentence to read as follows: "The President shall vote in meetings of the House of Delegates, but shall vote in the general meetings and in the Council only in the case of a tie."

(c) In the last sentence strike out the words "th House of Delegates,".

ARTICLE VIII

Section 1. In the fourth sentence after the word "Editor" insert ", the Speaker of the House of Delegates'

The purpose of the several amendments to the By-Laws is to provide for the election by the House of Delegates of a Speaker of the House of Delegates, and to prescribe his duties. Certain duties heretofore performed by the President will be transferred to the Speaker.

J. MORRISON HUTCHESON, M.D., *Chairman*
RICHARD P. BELL, JR., M.D.
J. D. ZYLMAN, M.D.

Medical Service

During the year, the Committee on Medical Service has been actively considering various problems currently of State and National interest in this area.

On January 5, 1954, its subcommittee on Indigent Care sponsored a state-wide meeting in Richmond, jointly arranged by The Medical Society of Virginia and the Virginia Council on Health and Medical Care. Invited to this assembly were representatives of local medical societies, welfare groups. Boards of Supervisors, and others concerned with the care of this important group. Upwards of 250 individuals attended. Discussion concerning the operation of our State plan, possible future developments, and the difficulties involved were taken by individuals having experience in the field. Constituent medical societies were urged to devote one meeting to the problems of indigent care, inviting like groups to participate.

Members of the Health Insurance Council, who represent commercial insurance carriers, were present by invitation at several of our meetings for discussion of mutual interests. In the opinion of our Committee, this liaison should be maintained. The report of the subcommittee on Prepayment Insurance follows: "Realizing that the high cost of medical care has resulted in a feeling of resentment by the general public against physicians as a group, this committee has been instructed to look into

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the advisability of gathering and publishing an average fee schedule throughout the State of Virginia.

It is the feeling of the subcommittee, as well as the Medical Service Committee as a whole, that such an average fee schedule is not practical and would actually be harmful to many physicians and probably cause more misunderstandings between physicians and their patients. The reason for this feeling is that from our studies it has been shown that the variation in fees for similar procedures varies geographically more than on any other basis, and what would be considered a fair or ordinary fee in one part of the state, would be much too high in another part of the state and vice versa. For this reason, the idea of gathering and publishing a fee schedule for the State of Virginia has been dropped.

In place of this, it has been suggested that each component of the State Medical Society appoint a committee to find out the average fees charged in their respective localities and that the members of each component Medical Society be given a list of these fees for their own use with the understanding that such a fee is to be charged unless the patient is told before treatment that the charge will be in excess of the average.

It is further thought that this schedule can be given to the State Insurance Commission and various insurance companies who are interested in selling health coverage so that their policies may be fitted to cover the needs of the patients.

It is the feeling of the subcommittee that such a plan is entirely feasible and that the House of Delegates would be asked to endorse the plan and to set up machinery by which each component society will be made aware of these suggestions and begin to act upon them as soon as possible." This material should be considered at our next State meeting.

Our Committee urges the profession to cooperate with Blue Cross and Blue Shield to prevent abuse through the over-utilization of these services. Their continued success merits the thoughtful consideration of every member of the medical profession. We have kept in close touch with legislation developing in the Congress on various types of health insurance.

The activities of the subcommittee on Rural Health follows: "The activities of the subcommittee on Rural Health this past year were twofold: (1) It acted in an advisory capacity to the Steering Committee of the Virginia Council on Health and Medical Care in its Orange County Health-Inventory Study. (2) It arranged a panel discussion meeting between representatives of the State Medical Society, the Virginia Council on Health and Medical Care, and leaders of the different farm organizations. This meeting was held as a part of the Institute of Rural Affairs at Virginia Polytechnic Institute and lasted two hours. Topics covered were the facilitating of medical service through better cooperation between doctors and the public, the utilization of the resources of preventive medicine through public health work and private practice, and a preliminary report on the results of the Orange County Health Study towards improving rural health. Discussion at the meeting was spirited, and it is felt that much good in improving mutual relationships between physicians and rural population was accomplished." We recommend that our Society continue to concern itself with the ever present problems presented in carrying medical service to the rural people.

The subcommittee on Industrial Health conducted a survey to determine the interest of our profession in the industrial health field. From its findings, we believe that it is well worth while at some future date to hold a state-wide meeting to bring before the physicians of the State some of the pertinent problems involved in this type of practice.

It was decided to recommend to the State Department of Health that an exhibit on industrial medicine be prepared for the 1955 annual meeting. The exhibit could emphasize the types of service which can be rendered physicians in plants throughout the state.

A follow-up is planned with respect to the possibility of the State Department of Health employing a full-time director for the Department of Occupational and Industrial Medicine.

We are pleased that the Society was represented at the meeting of the Council on Industrial Medicine, which was held this year in Louisville.

Chronic illness deserves especial mention. Large segments of the population whose life span has been increased make this area of service a real challenge. The ravages of diseases, such as rheumatic heart disease, polio, spastic paralysis and others in the young are also of great importance. National interest is evidenced by the work being done by the Commission on Chronic Illness. More recently Congress has recognized this field by appropriating money to be used for this particular purpose under the auspices of the Hill-Burton Act. Liaison with the Virginia Council on Health and Medical Care, the State Health Department and the Virginia groups has already been established to meet this challenge.

One of our most interesting meetings was held in Williamsburg, where an opportunity was had to visit the Patrick Henry Hospital for Chronic Disease, which is an on the spot view for this stimulating successful demonstration of community cooperative effort to do something for elderly people with chronic disease. We recommend your careful consideration of this subcommittee report: "(1) There is a pressing need for adequate facilities in Virginia to care for an ageing population and the chronically ill. (2) A hospital to render the service should be closely allied with a general hospital to insure adequate medical services and at the same time afford economical care. (3) The facility for the chronologically ill is a local problem and it should be recognized by the locality and assumed as a local responsibility free of government control and interference. (4) The locality served should be limited by the interest of the people in the institution, for its support and operation will depend on gifts and donations if its operation is to be kept under the revenue derived from patients. (5) It is suggested that other sections of Virginia would profit by the experience of the Patrick Henry Hospital for the Chronically Ill. The authorities of that institution have offered its entire op-

erations for study and its experience to other localities that may desire to establish such an institution."

Hospital-physicians relationships were considered, and the report of that subcommittee points out that 73 hospitals in Virginia have been surveyed and that 54 are fully accredited, 13 provisionally accredited and 6 not accredited. It is believed that physician in hospitals should unite their efforts in a campaign to make sure that all hospitals meet the requirements of the Joint Commission on Accreditation.

We were fortunate in having members of the A.M.A. Council on Medical Service Staff at several of our meetings to give us advice and help.

Finally, the Chairman would like to convey to every member of our Committee as well as those of the subcommittee his appreciation of the time and effort in tackling the problems presented. It is heartening to find such devotion to the profession. More of us must face issues involved in medical service and show the public that we are aware of the gaps to be filled in this area.

H. B. Mulholland, M.D., *Chairman*
J. G. Graziani, M.D.
F. A. Farmer, M.D.
T. B. McCord, M.D.
C. L. Savage, M.D.
R. V. Buxton, M.D.
Kinloch Nelson, M.D.
J. P. Williams, M.D.
H. M. Frieden, M.D.
S. C. Hall, M.D.

Membership

The Committee on Membership of The Medical Society of Virginia had no matters referred to it during the year, and consequently no meetings were held.

It is always gratifying to welcome into the Society those members admitted through their component societies since the last annual meeting. They are as follows:

Dr. Avis Branch Adams, Emporia
Dr. James Belt Adams, Emporia
Dr. Lloyd Campbell Agnew, Lynchburg
Dr. William Cooke Andrews, Norfolk
Dr. Franklin Lynwood Angell, Roanoke
Dr. Rolf Gunther Baginsky, Martinsville
Dr. Clifford Edward Bagley, Arlington
Dr. Allston Gibbes Bailie, Richmond
Dr. William Francis Barry, Clifton Forge
Dr. Ernest Lovell Becker, Randolph AFB., Texas
Dr. Houston Lesher Bell, Roanoke
Dr. Eugene Bene, Norton
Dr. Rack Foy Benthall, Alexandria
Dr. Wesley Clifford Bernhart, Annandale
Dr. Gordon Gilbert Birdsong, Franklin
Dr. James Currie Blair, Imboden
Dr. William Francis Blair, Norfolk
Dr. Elam Withrow Bosworth, II, Lexington
Dr. Walter Joseph Brennan, Jr., Petersburg
Dr. Carl Ashton Broaddus, Newtown
Dr. Milton Henry Brockmeyer, Pulaski
Dr. Henry Armistead Bullock, Jr., Richmond
Dr. Henry Griffin Bullwinkel, Fredericksburg
Dr. Frank A. Carroll, Alexandria
Dr. Warren Smoot Carter, Winchester
Dr. Leah Huntley Cate, Brightwood
Dr. Gordon Frank Cavell, Victoria
Dr. Charles David Cawood, Middlesborough, Ky.
Dr. Claire Althea Christman, Arlington
Dr. Vernon Lonsdale Cofer, Jr., Norfolk
Dr. George Henry Cook, Chincoteague
Dr. Robert Raymond Cook, Jr., Norfolk
Dr. Armando Ralph Coppola, Newport News
Dr. James Wendel Creef, Norfolk
Dr. Hubert Dinwiddie Crow, Fredericksburg
Dr. Charles Harper Crowder, Jr., South Hill
Dr. Alfred Mills Decker, Jr., Richmond
Dr. Adrian Joseph Delaney, Alexandria
Dr. Chester William Dewalt, Jr., Virginia Beach
Dr. Clara King Dickinson, Marion
Dr. Austin Ingram Dodson, Jr., Richmond
Dr. George Edward Ewart, Richmond
Dr. Cyrus Creston Farrow, Jr., Norfolk
Dr. Louis Zephirin Fauteux, Jr., Falls Church
Dr. Ernesto Fessel, Richmond
Dr. Gerald John Fisher, Arlington
Dr. Marion White Fisher, Sandston
Dr. Robert Irving Fleming, Amonate
Dr. James Stephenson Foster, Jr., Dante
Dr. Hugh Ross Fraser, Smithfield
Dr. John David French, Pearisburg
Dr. Milton David Friedenberg, Richmond
Dr. Asher Arthur Friedman, Norfolk
Dr. Lois Fox Fryer, Arlington
Dr. James Wilson Fullerton, Tazewell
Dr. Robert Barnett Gahagan, Norfolk
Dr. Earle Carlton Gates, Chester
Dr. Harold Louis Goldman, Norfolk
Dr. Harvey Winfrey Goode, Jr., Dinwiddie
Dr. Samuel H. Gould, Hopewell
Dr. Jerome Stanley Gross, Norfolk
Dr. George Parker Hand, Jr., Norfolk
Dr. Roy Belmont Hargrove, Jr., Farmville
Dr. Kirby Thompson Hart, Jr., Petersburg
Dr. Forrest Moseley Haswell, South Boston
Dr. Benjamin Hines Harrison, Hampton
Dr. Joseph Haven Hoge, Sandston
Dr. James Reuben Holsinger, Luray
Dr. Mark Edgar Holt, Jr., Petersburg
Dr. Charles Perry Howze, Charlottesville
Dr. George William Hurt, Roanoke
Dr. William Robert Irby, Richmond
Dr. Harold Joseph Jacobs, Jr., Norfolk
Dr. Robert McClain Jamison, Covington
Dr. Julio Jimenez-S, Stuarts Draft
Dr. Francis Seymour Jones, Norton
Dr. Arthur Sanford Kaplan, Norfolk
Dr. Lee Norman Kastner, Portsmouth
Dr. Saul Kay, Richmond
Dr. Eusebius Milton Kellam, Nassawadox
Dr. John Wise Kellam, Belle Haven
Dr. Earle Jerome Kerpelman, Norfolk

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Dr. Joseph A. Kiesel, Arlington
Dr. Robert Gillis Kindred, Charlottesville
Dr. Richard Horace Kirkland, Richmond
Dr. William Joseph Kucewicz, Norfolk
Dr. Robert A. W. Latimer, Manassas
Dr. James John Lawson, Jr., New Market
Dr. Herbert Murray Levitt, Petersburg
Dr. Eugene Bell Linton, Altavista
Dr. Murdo Macaulay Mackay, Clifton Forge
Dr. Franklin Martin, Jr., Charlottesville
Dr. George Vincent Martin, Norton
Dr. Charles Webster Massey, Richmond
Dr. Charles Francis McCaffrey, Arlington
Dr. Dennis Parfremont McCarty, Front Royal
Dr. Robert Burns McEwen, Wakefield
Dr. Thomas Francis McGough, Alexandria
Dr. Maurice Albert Michael, Suffolk
Dr. James DeWitt Mills, Jr., Alexandria
Dr. Philip Lee Allen Minor, Richmond
Dr. Arthur Vernon Mitchell, Arlington
Dr. Cary Nelson Moon, Jr., Charlottesville
Dr. Ray Atkinson Moore, Jr., Hampden-Sydney
Dr. Helen Luella Morton, Richmond
Dr. James Mercer Moss, Alexandria
Dr. William Francis Murphy, Jr., Norfolk
Dr. John Alexander Murray, Franklin
Dr. Donald Stover Myers, Hot Springs
Dr. Sigmund Newman, Arlington
Dr. George Maynard Nipe, Harrisonburg
Dr. James Lee Northington, South Hill
Dr. John Anthony Opal, Bristol
Dr. William Joseph O'Rourke, Richmond
Dr. Maysville Jane Page, Richmond
Dr. Robert Edward Paine, Jr., Salem
Dr. Carl Putnam Parker, Jr., Falls Church
Dr. John Legerwood Patterson, Richmond
Dr. Francis Robert Payne, Jr., Petersburg
Dr. Carroll A. Peabody, Petersburg
Dr. Julius Peerless, Norfolk
Dr. Robert Mason Phillips, Chester
Dr. Norman William Pinschmidt, Richmond
Dr. Daniel Wells Pratt, Charlottesville
Dr. Douglas Theodore Prehn, Arlington
Dr. Ralph Price, Warwick
Dr. John Stuart Prince, Emporia
Dr. Oliver James Purnell, Richmond
Dr. Rupert Wilson Quaintance, Jr., Culpeper
Dr. Stuart Ragland, Jr., Richmond
Dr. John Lewis Read, Richmond
Dr. Delbert Joseph Richard, Alexandria
Dr. William Clayton Robertson, Jr., Portsmouth
Dr. Paul Ward Robinett, Portsmouth
Dr. Henry Moore Rogers, Jr., Norfolk
Dr. Frederick William Rook, Arlington
Dr. Sidney Rosenbaum, Arlington
Dr. Edward Howard Scherr, Richmond
Dr. Eugene William Senter, Salem
Dr. Robert Dayton Shreve, Altavista
Dr. Homer Alden Sieber, Roanoke
Dr. Edward Valentine Siegel, Newport News
Dr. Harvey Daniel Smallwood, Charlottesville
Dr. Catherine Wood Richard Smith, Abingdon
Dr. John Earle Smith, Highland Springs
Dr. James Hal Smith, Christiansburg
Dr. Russell Smith, Piney River
Dr. Norman Sollod, Petersburg
Dr. Charles Hallacy Spencer, Clinchco
Dr. Peter Weaver Squire, Emporia
Dr. Carl Ellroy Stark, Wytheville
Dr. Thomas Weir Stewart, Lynchburg
Dr. Spottswood Douglas Stoddard, White Stone
Dr. William H. Stout, Hopewell
Dr. Charles Franklin Tate, Jr., Charlottesville
Dr. Gervas Storrs Taylor, Jr., Norfolk
Dr. Harry Baylor Taylor, Jr., Norfolk
Dr. William Sanford Terry, Portsmouth
Dr. John Samuel Thiemayer, Jr., Norfolk
Dr. Acors William Thompson, Falls Church
Dr. Oscar Andreas Thorup, Jr., Charlottesville
Dr. Robert Henry Thrasher, Norfolk
Dr. Thomas Roper Travis, Montross
Dr. George Edward Troxel, Winchester
Dr. Grattan Howard Tucker, Jr., South Hill
Dr. Jesse Miller Tucker, Jr., Huddleston
Dr. Harold T. Turner, Narrows
Dr. Frederik Marie Van den Branden, Denbigh
Dr. John Heath Vaughan, Richmond
Dr. Ruth Vingiello, Blacksburg
Dr. Fred Walls, Jr., Richmond
Dr. Benjamin Boisseau Weisiger, III, Alexandria
Dr. W. Leonard Weyl, Arlington
Dr. William Harvey Whitmore, Jr., Norfolk
Dr. Philip Abney Wilhite, Jr., Portsmouth
Dr. David H. Williams, Boissevain
Dr. William Overton Winston, Portsmouth
Dr. Henry Wise Wood, Norfolk
Dr. John Julius Yaeger, Lexington
Dr. James Robert York, Berryville
Dr. Charles Merriwether Zacharias, Richmond
Dr. Francis Louis Zinzi, Arlington

The Committee takes pleasure in recommending for honorary membership in The Medical Society of Virginia our distinguished retiring President, Dr. Vincent W. Archer, Charlottesville.

GEORGE W. LEAVELL, M.D., *Chairman*
JAMES A. THWEATT, M.D.
HENRY J. LANGSTON, M.D.

Public Relations

Medical public relations activity in Virginia reached a new high during the past year, and much of the credit belongs to the PR committees of component medical societies. Never before have the component societies been so active and never before have the results been so gratifying.

The 1953-54 PR program was officially ushered in with the Annual *Public Relations Conference*, which was held in Richmond on November 24. One of the big PR needs stressed at the Conference was that of a strong, active

Auxiliary, and it is a real pleasure to report that two new component auxiliaries have been organized.

Auxiliary PR efforts received an additional boost with the appointment of Mrs. R. M. Reynolds, Norfolk, as *Public Relations Chairman of the Woman's Auxiliary to the American Medical Association.*

A PR project strongly recommended at the Conference was the presentation of *Public Medical Forums,* and at least three Virginia cities—Lynchburg, Norfolk, and Alexandria—had forums sponsored by their medical societies. It is quite likely that forums will be presented in Richmond and Newport News sometimes this fall. Forums already staged attracted "standing room only" attendance, and the matter of finding meeting halls with the necessary seating capacity was not easy.

Radio and TV public relations were also stressed, and the Committee believes that great strides have been made in these fields. Since the first of the year, 300 programs totaling 75 hour have been aired. Lynchburg and Norfolk were scenes of particular activity, although just about every section of the state was covered to some extent.

At the present time, 18 radio stations are carrying radio PR programs. One of these (WMBG—Richmond) is carrying a daily program. It seems fairly safe to predict that 25 stations will be using our programs certainly by the first of the year. Such a radio public relations program is possible only because The Medical Society of Virginia has been designated a transcription distribution center by A.M.A. More than 60 series of transcriptions are now available from the state office.

Six TV stations have gone all out to telecast the many excellent medical PR films made available by the Society. Thus far, 17 programs have been telecast—a total of 8 hours.

The Committee initiated a new project involving the distribution of sound public relations literature through the medium of *community welcome wagons.* Although this had been done in several localities (notably Lynchburg and Arlington), it had never before been attempted on a state wide basis. Welcome wagon supervisors in 16 communities have been contacted and the project cleared with the various component societies. Already, newcomers to 12 communities are receiving information about the importance of securing a family physician, etc. This could easily become the most worthwhile of all PR activities.

In an effort to assist and stimulate component societies in their public relations activities, a *PR handbook* was compiled and sent all public relations chairmen.

An undertaking of considerable importance, not only in Virginia, but the entire nation, got under way in the Fredericksburg area. A *crash injury research project,* sponsored by the Cornell University School of Medicine, is being conducted with the cooperation of The Medical Society of Virginia, the State Department of Health, and the State Police. The public relations significance cannot be overlooked. Here is a positive approach to good public relations, and the Fredericksburg Medical Society is to be congratulated for its complete cooperation in supplying the medical data needed to insure the project success. It is hoped that other medical societies will give the same cooperation should the project be shifted to their areas.

Current Currents, the PR newsletters, continued to be sent the membership each month. In addition, eight *Bulletins for Office Personnel* were sent out and continued to receive a good response. Present policy is to include, with each issue of Current Currents, a copy of some important piece of literature available in quantity from the state office.

In this connection, the Committee has been waging a real campaign to get our members to display and otherwise utilize the very informative *pamphlets, booklets, reprints,* etc. available for the asking. A *traveling exhibit* was used to publicize the material at meetings of component societies and special mailings were employed in some instances. As a result, a record breaking 40,600 pieces of literature have been distributed during the year.

An exhibit entitled "Health 1953" was presented at the Atlantic Rural Exposition, and once again, it was the cooperation of the Woman's Auxiliary to the Richmond Academy of Medicine that made it possible. It is estimated that 125,000 visitors viewed the exhibit over a nine day period.

During its last meeting, your Committee arranged the program for the next State-wide *Public Relations Conference,* which will be held at Charlottesville's Hotel Monticello on November 18. We cannot emphasize enough the importance of having every component society well represented.

Although much has been accomplished in public relations during the past twelve months, the Committee realizes only too well that the surface has barely been scratched. Good medical public relations will exist in Virginia only when each physician takes it upon himself to be a public relations committee of one. Remember—PR means *Personal Responsibility.*

JAMES P. KING, M.D., *Chairman*
BENJAMIN W. RAWLES, M. D.
JOHN W. DAVIS, JR., M.D.
MASON C. ANDREWS, M.M.
H. C. BATES, JR., M.D.
FRED D. MAPHIS, M.D.

House

Your House Committee is pleased to announce that in October 1953, the Virginia Mental Hygiene Society moved to an unoccupied room on the second floor of the headquarters building of The Medical Society of Virginia. We are also glad to report that both categories of expenditures at 1105 West Franklin Street, viz:—Building Repair and Building Maintenance, have fallen well within the respective budgets for these items.

Five hundred dollars was set aside to cover building repairs and $66.00 has been spent. This was expended to replace a warped and weakened wooden pillar supporting the second story of the back porch and several planks on this porch which were rotting and presenting a hazard to life and limb.

Two thousand-five hundred dollars was budgeted for

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Building Maintenance. The largest non-predictable expense this year was the need to paint the entire exterior wood and iron work, the roof, and the rather drab second floor rear hall way and the back stairs at a total cost of $575.00.

The following more or less routine expenditures were also incurred during the past year:—

Utilities (light, gas & water)	$ 290.53
Supplies (Janitorial & Housekeeping)	161.96
Fuel	275.39
Fire Insurance	25.00
Upkeep (Includes painting as stated above)	750.52
Janitor's Salary	981.63
Taxes on Property	323.40
	$2807.91

Fortunately the two headquarters offices occupied on the second floor by the Virginia Academy of General Practice and the Virginia Mental Hygiene Society contributed $630.00 toward the building maintenance and this reduced the total cost to $2177.91, which was well within the past year's budget.

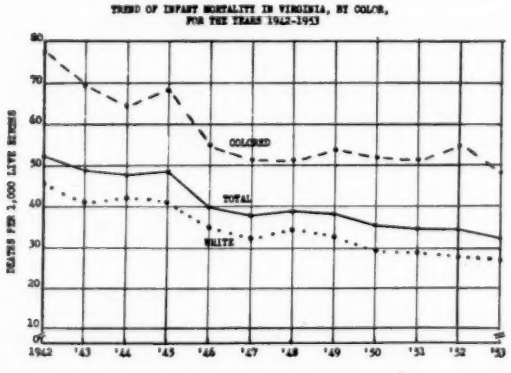
DONALD S. DANIEL, M.D.
FLETCHER J. WRIGHT, JR., M.D.
HARRY J. WARTHEN, JR., M.D., *Chairman*

Child Health

The committee has met twice—in Roanoke in October and at Hot Springs in February.

The study has continued of the deaths of premature infants who were born at home. The circumstances of each case are assembled by the staff of the State Health Department and members of our committee have then expressed an opinion as to whether the death was preventable and, if so, how it could have been prevented. The results of these studies are being used in planning further measures for the care of the newborn. It is the feeling of the committees that this work should continue as it offers hope of reducing premature infant mortality.

A chart is presented which shows the trend of infant mortality rates in Virginia for the years 1942-1953. The total Virginia rate of 32.4 in 1953 is significantly higher than the United States rate of 27.8. When the Virginia rate is broken down to show the effect of color, the white rate is seen to be 27 in striking contrast to the much higher rate of 47 for the colored population.



These figures speak for themselves and show the need for improved infant care, especially for the colored. No one today knows what the irreducible minimum of infant mortality may be, but one fact is certain—any rate for a state or city which is higher than the rate for another state or city indicates that some babies there are dying unnecessarily and that the rate in question is not yet at the irreducible minimum.

Together with several other interested organizations the committee sponsored the Institute of Premature Care which was held in Richmond on April 1st and 2nd, 1954. More than 200 nurses from all over the State who deal with newborn and premature infants made up a receptive and enthusiastic audience.

The committee is promoting the new Manual of Newborn Care which has been published by the American Academy of Pediatrics as the standard reference book for all hospital nurseries in the State. We feel that the adoption of this outline of procedures and safeguards would materially reduce neonatal mortality.

An improved program where health services are more universally obtainable by the school age child from his own physician is now under study. In cooperation with the State Health Department we are also formulating plans for medical care of the child who cannot or will not go to his own physician. This is to be done through school health service clinics run by clinicians picked from a panel of local physicians. We are particularly interested in improving methods of screening school children for defects and in more effective follow-up by which defects can be corrected promptly. We feel very strongly that large scale health round-ups as presently carried out, with their necessarily superficial examinations are a waste of time both for the patient, the physician, and the attending nurse.

MCLEMORE BIRDSONG, M.D.
EDWIN KENDIG, M.D.
PAUL HOGG, M.D.
JOHN WALKE, M.D.
JOHN RYDEEN, M.D.
WILLIAM CHAPIN, M.D.
EDWIN HARPER, M.D., *Chairman*

To Confer with the State Board of Nurse Examiners

The Committee to Confer with the State Board of Nurse Examiners appointed by Dr. Vincent W. Archer, President of The Medical Society of Virginia, 1953-4, has, at the time of this writing, had no formal meetings and has had no request, either from physicians or nurses, to consult.

RUSSELL V. BUXTON, M.D.
JAMES M. HABEL, M.D.
MALCOLM H. HARRIS, M.D.
FRANK JOHNS, M.D.
EUGENE L. LOWENBERG, M.D.
JOHN A. SHACKELFORD, M.D.
C. BRUCE MORTON, 2ND, M.D., *Chairman*

Venereal Disease Control

The Venereal Disease Committee of The Medical Society of Virginia recommends the establishment of a state supervised laboratory for the performance of the T.P.I. test or a similar test for the detection of syphilis for the benefit of all physicians in Virginia.

WILLIAM H. KAUFMAN, M.D.
HARRY PARISER, M.D.
ALLEN PEPPLE, M.D.
W. R. SOUTHWARD, JR., M.D.
J. W. LOVE, M.D., *Chairman*

Tuberculosis

One meeting has been held which was attended by most of the committee. Those who were not present were contacted by mail in regard to any ideas they might have on the control of tuberculosis in Virginia. During the past several years there has been marked activity on the part of the Virginia Tuberculosis Association with the survey of the tuberculosis facilities of the entire state. This culminated in certain recommendations to the Legislature which were partially adopted at its last meeting. The Governor's Advisory Committee was also appointed by Governor Battle and this committee functioned for about one year. Since Governor Stanley came into office, this committee has not yet been appointed. It is recommended that the House of Delegates recommend to Governor Stanley that the Advisory Committee on Tuberculosis be again set up. New recommendations should be made for the next meeting of the State Legislature.

E. C. DRASH, M.D., *Chairman*

Mental Hygiene

The Mental Hygiene Committee of The Medical Society of Virginia has not functioned with the vigor equal to that of your committee of 1953, under the chairmanship of Dr. David C. Wilson. Our only meeting was held in Richmond on July 30, 1954. In general, the objectives of the committee are in accord with the objectives as outlined in the 1953 report.

Our committee received a report from the chairman of the Special Committee on Blue Cross-Blue Shield Hospital Insurance for patients suffering from emotional and mental disorders. Since the State Corporation Commission's action was unfavorable toward insurance coverage for psychiatric patients, it was recommended that the special committee, under the chairmanship of Dr. J. R. Saunders, be continued and that the Commission be written a letter embodying their recommendation of last year. A copy of this letter is to be sent to Dr. Vincent W. Archer, President of The Medical Society of Virginia, and to Dr. Richard J. Ackart, Executive Director of the Virginia Hospital Service, Incorporated. This letter will, in addition, request that a representative of this committee be allowed to be present at the next meeting, or hearing, that deals with insurance coverage of psychiatric patients.

Our committee sponsors more substantial support of the Mental Health Association of Virginia by the medical profession throughout the state. For the past year this organization has carried on a well planned educational program and has maintained an office in The Medical Society of Virginia Building at 1105 West Franklin Street, Richmond, Virginia.

During the past year the Mental Health Association of Virginia has retained a full time executive officer for the first time in its sixteen years of existence. The initial financial burden on the organization has been unusually heavy. Our committee unanimously recommended that The Medical Society of Virginia donate office rent ($30. per month) to the Mental Health Association of Virginia for a period of one year retroactive from July, 1954.

A suggestion was made and approved, to the effect that a plan be worked out with the Department of Mental Hygiene and Hospitals to better inform the physicians throughout the state with the commitment laws.

Our committee was informed that the Richmond Academy of Medicine was sponsoring a series of medical forums with the cooperation of The Richmond Times-Dispatch and Radio Station WRNL. Our committee endorsed this plan and approved a further suggestion that we request the Publicity Committee of the Richmond Academy to have their first program on Mental Health.

There was considerable discussion of the nursing home situation throughout the state. The question was raised as to the responsibility for the medical and psychiatric care of patients in these institutions. Our committee recommends that The Medical Society of Virginia authorize a survey sufficient to determine the status of the care and treatment of patients in nursing homes and further to establish standards both as to the medical and psychiatric supervision of the patients in nursing homes.

During 1953, the committee on Mental Health of the American Medical Association, with the approval if the Board of Trustees of the American Medical Association, established a sub-committee on alcoholism. There has been considerable correspondence and communication between the secretary of the sub-committee on alcoholism of the American Medical Association and the committee on Mental Health of The Medical Society of Virginia. We were urged to establish a similar committee in our state. In addition, the sub-committee of the American Medical Association was particularly interested in our mental health program in Virginia, as outlined in our report of last year. They felt that Virginia had an outstanding program and wanted a representative from our committee to have a prominent place on their program. Dr. David C. Wilson was appointed chairman of our subcommittee and will be on the program at a meeting being held in Chicago, Illinois, at the American Medical Association's headquarters on September 17th and 18th, 1954. One objective of this meeting in Chicago is to get all the state medical societies to develop a more definite program relative to the alcoholic problem. A written report on this meeting cannot be made until the annual meeting of The Medical Society of Virginia in 1955.

REX BLANKINSHIP, M.D., *Chairman*
DAVID C. WILSON, M.D.

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JAMES K. MORROW, M.D.
JOHN R. SAUNDERS, M.D.
C. T. WILFONG, M.D.
JOSEPH R. BLALOCK, M.D.
EDWIN J. PALMER, M.D.
THOMAS N. SPESSARD, M.D.
JOHN POWELL WILLIAMS, M.D.
JOHN A. SIMS, M.D.
SNOWDEN C. HALL, M.D.
THOMAS H. ANDERSON, M.D.
THOMAS S. EDWARDS, M.D.
ALEXANDER G. BROWN, III, M.D.
JOHN B. McKEE, M.D.
W. S. HOOTEN, M.D.
LANDON E. STUBBS, M.D.

Cancer

The Cancer Committee received last fall an advisory report from the American College of Surgeons' Inspector after his visit to some of the Tumor Clinics certificated by the Committee. After a review of the report, in conjunction with the usual annual reports from the clinics, all old clinics were extended re-certification for the year, October, 1953 - October 1954.

Since last October, the Norfolk Diagnostic Tumor Clinic has disbanded. As a result, three applications for new clinics were received and approved by the Committee. These are the DePaul Hospital Tumor Clinic of which Dr. Harold J. Jacobs is Director, the Norfolk General Hospital Tumor Clinic—Director Dr. Arnold J. Rawson, and the Portsmouth Diagnostic Tumor Clinic with Dr. Lemuel E. Mayo the Director. In addition, two other new clinics have been organized and approved—The Dixie Hospital Tumor Clinic at Hampton with Dr. W. H. Parker and Dr. F. A. Kearney as co-Directors, and the Norton Diagnostic Tumor Clinic of which Dr. C. L. Henderson is the Director. Eighteen clinics holding certification from The Medical Society of Virginia through this Committee are now in operation, and there is interest in organizing others in several areas.

The Committee has published a series of Cancer Bulletins in the Virginia Medical Monthly.

The Committee has been called on for advice about policies concerning services rendered to cancer patients by the Virginia Division of the American Cancer Society, the details of which are recorded in the Minutes of the Committee meetings.

A. B. GATHRIGHT, M.D.
JOS. W. HOUCK, M.D.
NELSON SMITH, M.D.
CHAS. H. PETERSON, M.D.
F. D. DANIEL, M.D.
A. P. JONES, M.D.
MASON ROMAINE, M.D.
J. J. GIESEN, M.D.
J. R. KIGHT, M.D.
A. C. WYMAN, M.D.
GEO. ZUR WILLIAMS, M.D.
GEORGE COOPER, JR., M.D., *Chairman*

Rehabilitation

The Rehabilitation Committee, which also serves as the Professional Advisory Committee for the Vocational Rehabilitation Service, State Department of Education, has been actively engaged in its regular functions during the past year.

The members of the Committee, both individually and collectively have rendered consultative services to the staff of the Rehabilitation Agency throughout the year. Professional advice was given on many individual cases involving complicated medical problems. Also, the Committee has provided to the Agency professional guidance in regard to the professional fee schedule and operational procedures and policies pertaining to physical restoration.

A regular meeting of the Committee was held on May 2, 1954 at the John Marshall Hotel. In addition to official Committee members, those present were: R. N. Anderson, Director, Vocational Rehabilitation and Special Education; Dr. J. M. Mennell, Dr. John M. Stirewalt, and F. O. Birdsall of Woodrow Wilson Rehabilitation Center; Corbett Reedy and Floyd H. Armstrong of the State Rehabilitation Service; and E. H. Buckman, Film Production Service, State Department of Education. Drs. A. Ray Dawson and E. E. Haddock were presented as new members of the Committee.

A report on Woodrow Wilson Rehabilitation Center was presented which revealed substantial progress in average enrollment and services provided to disabled persons by this facility during the past year. Also, an interesting report was submitted by Dr. Frank B. Stafford, Superintendent, on the progress made in broadening the Rehabilitation Unit at Blue Ridge Sanatorium and projected plans for the future.

The Committee viewed the film, THE REHABILITATION STORY, which was produced by the Film Production Service of the State Department of Education and depicts the services rendered by the State Rehabilitation Agency. The Committee feels that it is an excellent film and commends it to medical groups for local showings.

ROY M. HOOVER, M.D., *Chairman*
GEORGE A. DUNCAN, M.D.
J. R. BLALOCK, M.D.
LEROY SMITH, M.D.
FRANK B. STAFFORD, M.D.
W. E. DICKERSON, M.D.
G. S. FITZ-HUGH, M.D.
FLETCHER J. WRIGHT, M.D.
A. L. CARSON, JR., M.D.
RENO PORTER, M.D.
EDWARD E. HADDOCK, M.D.
CHARLES L. SAVAGE, M.D.
A. RAY DAWSON, M.D.

Cerebral Palsy

There has been a gradual increase in services for cerebral palsy patients throughout the state. It is recognized that there are close to 30,000 patients so affected. This is a number comparable to the polio cases present in

the state. In the past, however, these patients have not been given the consideration which they deserve. They were considered mentally deficient and there appeared to be little hope for rehabilitation. This concept, however, has changed greatly in the past ten years. In spite of their physical disability many of them are found to be mentally normal.

Whereas no section of the state of Virginia was offering any appreciable amount of service to these patients ten years ago, it appears now that in practically all parts of the state they are receiving attention from orthopedists, neurologists and others. Many of these patients are being hospitalized and given physical therapy, surgery and other services which appear to be helpful. Under the State Crippled Children's Program, payment is being made to hospitals for room and board. The Virginia Society for Crippled Children and Adults also supports hospitalization for a number of these patients. The United Cerebral Palsy Society is also functioning in this state.

In the Northern Virginia Area, the Arlington Crippled Children's Program is offering an excellent program. The cerebral palsy patients receive not only orthopedic care, but services from various consultants. Physical and occupational therapy is offered to them. The Crippled Children's School which is in the same building offers real educational opportunities. The description of this building is offered so that other communities may consider using it as an example for future expansion in the field of cerebral palsy.

There is contained in the building three clinic rooms, an exercise room, two demonstration rooms, an occupational therapy department, a special woodworking department, an office for speech therapy, two nurses offices and a waiting room. The cerebral palsy cases are part of the Crippled Children's Program and utilize this building. In the physical therapy department routine cerebral palsy equipment is present such as relaxation chairs, standing tables, parallel bars, exercise steps, etc. There are two whirlpool tanks, and a Hubbard Tank will be installed in the near future.

All records are typewritten and there is a full time secretary. Files are kept of the patient's records, of his x-rays and there is an index card system. The cafeteria is used by any and all who are spending a greater portion of their day in the building. For example—the children in the socialization demonstration unit and children who are transported for a distance of 50 to 60 miles and who are spending from 4 to 6 hours at a clinic session. At the present time there is no cooking done in the cafeteria, but for the socialization group who are here regularly, food is brought in for serving. Other children bring their food with them and have access to the stove, refrigerator etc. The cafeteria is also used for the storage of cots for patients who are here for a sufficient time that rest periods are indicated.

In the demonstration rooms, occupational therapy for teaching daily activities has proven valuable. With a brain damaged child it is necessary for him to have hours of concentrated effort in teaching him to feed himself, button and unbutton his clothing, tie his shoes and other activities done by the normal child by instinct, or ordinary development by age. In one of the demonstration rooms it has been found necessary to observe, socialize, motivate and evaluate before the orthopedist can obtain results from his recommendations for physical therapy, gait training etc. This motivation is accomplished by bringing to the child group activities through music, the use of special equipment etc. An effort is made to bring out in each child his individual potentialities and make him aware of same. In another demonstration room, there are children whose conditions have been evaluated and who have been motivated as to their potentialities to cooperate with their treatment, but still have perceptual, conceptual, and/or behavior disorders and are in need of special techniques, other than the usual remedial procedure of teaching. He may, plus his physical neurological disorders, also have visual, hearing, speech and language difficulties. A special designated curriculum is available to these children in addition to their physical therapy, occupational therapy, rest periods etc.

At the Arlington Center it is believed that real progress has been made in cerebral palsy patients; however, it is hoped that with greater opportunities being offered in the field of rehabilitation as a result of recent federal legislation, that earlier and more complete rehabilitation will be accomplished. It is hoped to add a psychologist, vocational guidance counselor and others to the rehabilitation team. It is planned also to function closely with the Anderson Rehabilitation Center located in Arlington.

In Norfolk there is a well established cerebral palsy clinic. The program is handled by the orthopedic surgeons in that area. This community has become increasingly more interested in this program and is contributing greatly in making it an up to date center. The Virginia Society for Crippled Children and Adults functions closely with this program.

In the Richmond area, the Medical College of Virginia has a program for patients handicapped with this disorder. Regular clinics are being held and definite progress is being made. In other parts of the state the cerebral palsy cases are receiving care. The latter clinics have not been established with equipment and personnel to the extent noted in other parts of the state, but the interest of the doctors has increased considerably. The benefits from good orthopedic, neurological and psychiatric care is recognized and it is believed that an expansion of the program is only a matter of time.

Information is not available at this time concerning the program at the University of Virginia at Charlottesville. It is our understanding, however, that a special center is being contemplated for the care of cerebral palsy cases in that area.

Although the care of the cerebral palsy patient is one of the most difficult, these cases are no longer hopeless. Further advances will be made and it is believed that greater interest by the individual communities will prob-

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ably be the main factor in providing the attention that these individuals deserve.

O. ANDERSON ENGH, M.D., *Chairman*

Conservation of Hearing

At the present time the most comprehensive work on the conservation of hearing in Virginia is centered in the state's two medical schools; some efforts are being made to develop a Speech and Hearing Program in Norfolk and in other cities.

At the University of Virginia, under the guidance of Director J. M. Mullendore, Ph. D., and Malcolm B. McCoy, Audiologist of the Speech and Hearing Center, and under the medical supervision of Drs. Fletcher Woodward and G. S. Fitz-Hugh, of the Department of Otolaryngology, University of Virginia Hospital, an active program of audiometric testing, lip reading, speech instruction for hard of hearing, hearing aid evaluation, and auditory training is under way.

In addition, this department conducted a hearing survey of the Martinsville and Scottsville city schools, grades three through seven, and a resurvey of Charlottesville, the second in three years.

In Richmond, at the Medical College of Virginia, the Hearing Conservation activities of the Audiology center are supervised by S. James Cutler and under the medical leadership of Dr. P. N. Pastore of the Department of Otolaryngology.

For the past two years this group has conducted a hearing survey in the Richmond area and carried out the necessary remedial measures. With the help of the Junior League over twenty thousand school children were tested, and over one thousand four hundred children were sent to their private physicians or to the Ear, Nose and Throat clinic for treatment.

At the Audiology Center itself the work consists of audiometric and free field testing, hearing and evaluation, speech correction and reading, counseling and guidance of the hard of hearing patients and parents, and all phases of a complete audiological service.

The committee is interested in promoting additional Hearing Centers in the larger cities, and extending the hearing surveys of school children all over the state.

Efforts should be made to amplify the endeavor of the Richmond group in acquainting the public, over the radio and other media, with the facilities available in Virginia for the Conservation of Hearing.

P. N. PASTORE, M.D.
NEIL CALLAHAN, M.D.
JAMES GORMAN, M.D.
FRED HAMLIN, M.D.
GRANT PRESTON, M.D.
FLETCHER WOODWARD, M.D.
J. H. HOPKINS, M.D.
FRANCIS H. MCGOVERN, M.D., *Chairman*

Liaison to the United Mine Workers Welfare and Retirement Fund

This Committee has had, to this date, no meetings, since the one of the American Medical Association on September 13 and 14, 1953.

The Medical Service Committee of the American Medical Association has called the third Annual Conference on Medical Care in the Bituminous Coal Mining Area to be held in Huntington, West Virginia on October 22nd and 23rd. We feel that this is an experimental type of hospital and medical care program involving the bituminous coal worker. The American Medical Association is attempting to cooperate in establishing future policies.

The report on the meeting in Charleston in 1953 has been published previously and the one in October will be submitted accordingly after this meeting.

JAMES P. WILLIAMS, M.D., *Chairman*
KINLOCH NELSON, M.D.
MACK I. SHANHOLTZ, M.D.
JOHN O. BOYD, JR., M.D.
RUFUS P. BRITTAIN, M.D.
H. B. MULHOLLAND, M.D.

National Emergency Medical Service

During the past year the above committee has carried out the requirements of the civil defense program as outlined in the September 1953 issue of the Monthly. The actual training of civil defense personnel has been started in both orientation and civil defense functions. This training is stressing medical service for natural as well as enemy caused disaster. Equipment and supplies for approximately 120 First Aid Stations has been ordered (most of it received), equipment has been ordered for four mobile emergency hospitals, and personnel therefor appointed by the University of Virginia Hospital, the Medical College of Virginia Hospital, the Winchester Memorial Hospital and two hospitals in Roanoke. It is planned to organize a fifth such hospital in the near future. A manual on Emergency Mortuary Services has been published as has one for Emergency Services and a Manual for Practical Nurses Training is under preparation. In conformance with recommendations of the Medical Advisory Committee of Region II, F.C.D.A., Emergency Medical Services has been made an integral part of the functions of the State and local health departments, and the personnel of such departments participate in these functions.

With the advent of the H-Bomb, certain fundamental policies of emergency medical service must be changed. We must expect greater numbers of casualties, not only from the actual detonation of such a bomb, but also large numbers from the "fall-out" of radioactive particles, which as has been proved, can cover several hundred miles. Under the dispersal plan, advocated by F.C.D.A., the services of all physicians as well as public health doctors, will be greatly needed.

This committee recommends that all of the component societies of The Medical Society of Virginia be requested to give at least one meeting a year, more if possible, to the study of emergency medical services, and the local civil defense plan particularly the expansion of local health services. Cooperation, advice and assistance of the

local medical society will greatly assist in the preparedness plans of the state. Each physician should review the treatments for burns, fractures, lacerations, shock and irradiation, so that should he be called upon for help will be familiar with the plan of the local chief of emergency medical services and what he is attempting to do.

W. R. SOUTHWARD, JR., M.D., *Chairman*

American Medical Education Foundation

The American Medical Education Foundation Committee for Virginia began the year with one goal—to make sure that contributions to the Foundation from Virginia physicians break all previous records. From all indications, that goal will be accomplished without too much difficulty.

From January through July, our records indicate that $5,876.19 has been contributed—compared with just over $3,000 for the same period a year ago. In fact, 1954 contributions already exceed the 1953 total of $4,854.75, and we still have time to widen the gap.

It should be stated, however, that the 1954 total includes a $2,000.00 contribution from The Medical Society of Virginia, authorized by the House of Delegates during the 1953 annual meeting.

The Committee sponsored a series of articles in the Virginia Medical Monthly which explained the importance of contributing to the Foundation, and pointed out how the medical schools in this country have been able to successfully resist encroachment by the federal government.

Committee members have also participated in programs of component medical societies in their areas. This enabled them to acquaint many Society members with the work of the Foundation.

A special letter bearing the signature of the President of The Medical Society of Virginia was sent to the membership along with a special contribution card. Response to the letter was most encouraging.

The Committee wishes to take this occasion to express its appreciation to the many physicians who are helping make 1954 a record breaking year in Virginia.

MARCELLUS A. JOHNSON, JR., M.D., *Chairman*
HARRY C. BATES, JR., M.D.
L. H. BRACEY, M.D.
MALCOLM H. HARRIS, M.D.
F. D. MAPHIS, M.D.
JOHN R. MAPP, M.D.
WALTER MCMANN, M.D.
RICHARD C. POTTER, M.D.
T. S. EDWARDS, M.D.
JAMES L. CHITWOOD, M.D.
LYDDANE MILLER, M.D.
JOHN H. DELLINGER, M.D.
CARRINGTON WILLIAMS, M.D.

Maternal Health

The Committee on Maternal Health of The Medical Society of Virginia met at the Commonwealth Club, Richmond, July 14, 1954. Those present were: Dr. H. Hudnall Ware, Jr., Chairman, Dr. Garrett Dalton, Dr. A. Tyree Finch, Dr. George S. Hart, Dr. Walter McMann, Dr. L. L. Shamburger, Dr. W. N. Thornton.

A report on the survey on maternal deaths for 1953 showed that 6 of the 88 cases were incomplete. This survey is now being conducted by personal visits through a representative of the Bureau of Maternal and Child Health of the State Health Department.

PERCENTAGE DELIVERIES BY PHYSICIANS AND BY MIDWIVES
VIRGINIA: 1936 - 1953

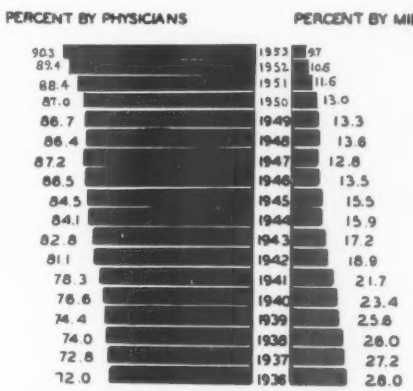

Chart No. 1 shows that there has been a gradual increase in the number of deliveries by physicians and a corresponding decrease in the number of deliveries by midwives.

TOTAL DELIVERIES AND DELIVERIES IN HOSPITALS
VIRGINIA: 1936 - 1953

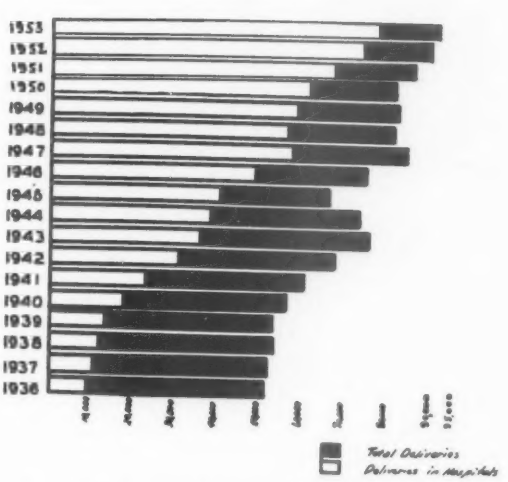

Chart No. 2 shows that there has been an increase in hospital deliveries as the total number of births increased. There were 91,831 births in the State during 1953 with 76,823 in hospitals.

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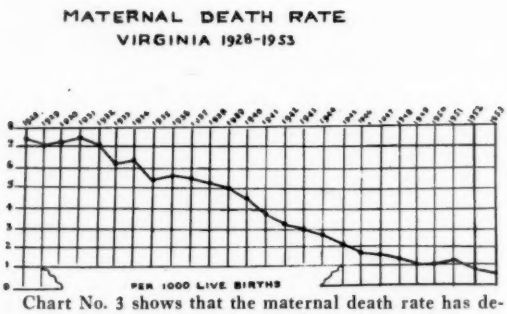

Chart No. 3 shows that the maternal death rate has decreased from 7.4 in 1928 to 0.7 in 1953. This rate compares with the national rate of 0.6

Chart No. 4 shows a decrease in maternal mortality as the hospital deliveries increased. The maternal mortality rate per 1,000 live births is determined by dividing the number of maternal deaths by the number of live births that occur during the year.

Charts were presented showing the number of deliveries by physicians, by midwives and in hospitals along with charts on maternal mortality rates. .

A report of the MCH activities revealed that there are 195 clinics being operated by 246 local physicians attending approximately 10% of the prenatal patients in the State. There were 1261 obstetric and pediatric cases hospitalized under the MCH program involving an expenditure of $186,601.48 during the period July 1st 1953-June 30th 1954.

Following a discussion of elective sterilization the Committee went on record as recommending that as many as 2 consultants render an opinion or that each hospital have a committee appointed for such consultation before sterilization was performed in any case.

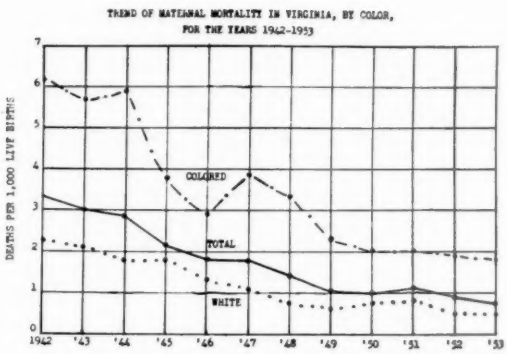
TREND OF MATERNAL MORTALITY IN VIRGINIA, BY COLOR, FOR THE YEARS 1942-1953
DEATHS PER 1,000 LIVE BIRTHS
COLORED
TOTAL
WHITE
1942 '43 '44 '45 '46 '47 '48 '49 '50 '51 '52 '53

Chart No. 5 shows a decrease in both white and colored maternal mortality rates but the colored rate has always been higher.

It was further recommended that all terminations of pregnancy be reported to the Bureau of Vital Statistics in order that comparable statistics with other States be on an intelligible basis.

There has been an occasional request for discontinuing silver nitrate as a prophylactic in the eyes of the newborn or that the State Board of Health designate a substitute. In view of the fact that confusion may arise particularly among midwives the committee recommends continuing the use of silver nitrate.

GARRETT DALTON, M.D.
A. TYREE FINCH, M.D.
E. S. GROSECLOSE, M.D.
GEORGE S. HURT, M.D.
JOHN R. KIGHT, M.D.
W. L. MCMANN, M.D.
EDWIN RUCKER, M.D.
L. L. SHAMBURGER, M.D.
W. N. THORNTON, M.D.
H. HUDNALL WARE, JR., M.D., *Chairman*

To Confer with the Old Dominion Medical Society

The Committee met and considered the problem of admitting negro physicians to membership in The Medical Society of Virginia. The apparent obstacle was found to be the word "white" in the Constitution of the Society. Being informed that our Judicial Committee's report would cover the proposed deletion of this word from the Constitution of our Society, we advised the Chairman of the Liaison Committee of the Old Dominion Medical Society that we were sure this matter would be considered and some decision made by the House of Delegates of The Medical Society of Virginia during its Annual Meeting this year.

The Committee believed that nothing further could be done until after the Annual Meeting this fall, so no other meetings were held. The Committee moves the adoption of this report and its own dissolution.

JAMES L. HAMNER, M.D., *Chairman*
GUY W. HORSLEY, M.D.

WALTER P. ADAMS, M.D.
FRANK A. FARMER, M.D.
HARRY C. BATES, JR., M.D.

Advisory Heart

This Committee had no matters referred to it during the year, and no meetings were held. Although a thorough study is being conducted to ascertain just how the Committee can best serve the membership, no formal report is offered at this time.

R. EARLE GLENDY, M.D., *Chairman*

Poliomyelitis

The chairman met with members of the State Health Department and of the National Foundation for Infantile Paralysis the middle of December, 1953 to hear Dr. John Marchand, of the headquarters office of the N.F.I.P. present plans for the use of the Salk Poliomyelitis Vaccine. Following this meeting members of the committee were polled and they approved the use of the vaccine in Virginia.

The committee was invited to attend a meeting on March 17, 1954, held in the chambers of the Corporation Court, to discuss the procedures of administration of the Salk vaccine in the areas in Virginia that had been declared eligible to receive it. Dr. Kenneth Layne, regional medical consultant of the N.F.I.P. presented the plans. Medical Directors of the designated areas, members of the central office of the State Health Department, state representatives of the N.F.I.P., members of the State Department of Education, the Superintendent of the Parochial Schools of the Roman Catholic Diocese, and the chairman of this committee were present.

On April 6, 1954, the chairman attended a meeting with representatives of the State Health Department to discuss the use of gamma globulin for poliomyelitis during the current year as outlined by the Office of Defense mobilization. This year it is distributed for use in group inoculations and not for single family or single household contacts. The recommended dose has been increased to 10cc.

April 9, 1954. The Medical Director of the City of Alexandria notified the State Health Department that the Medical Society of Alexandria had taken action the previous evening on the question of their approval of the participation of Alexandria in the field trials of the Salk Poliomyelitis Vaccine and had voted to decline the offer.

April 15, 1954. The Arlington County Medical Society rescinded their previous action and voted not to participate in the administration of the Salk Vaccine. This action left seven areas in the state in which the vaccine would be used—Loudoun, Fairfax, Henrico, Chesterfield and Norfolk Counties, the City of Bristol and Washington and Smyth Counties, and the City of Richmond.

On April 25, 1954, the N.F.I.P. authorized the release of the Salk Poliomyelitis Vaccine and on the following morning, Monday, April 26, 1954, the first dose to be given in the world in field trials of the vaccine, was administered to a boy in McLean, Fairfax County.

On May 24, 1954, the chairman and Dr. Robert C. Hood, of Arlington, represented the committee at a meeting to discuss what must be done throughout the polio season in the field trial areas in Virginia. Dr. Kenneth Layne, of the N.F.I.P. and Dr. Robert Korns, of the Poliomyelitis Vaccine Evaluation Center, Ann Arbor, Michigan, came to Richmond to attend this meeting and expressed their satisfaction at the completeness of the plans to follow through on children participating in the field trials.

August 19, 1954. The Office of Defense Mobilization notified the State Health Department that the use of gamma globulin for poliomyelitis has been extended to include the inoculation during the incubation period of all contacts of poliomyelitis not necessarily belonging to a larger group. It has been deemed advisable throughout to withhold gamma globulin for polio contacts in all field trial areas in order that the children who received the vaccine may have a normal exposure to the disease. The value of the vaccine as a protecting power is thereby more effectively determined.

As this report is submitted poliomyelitis cases are appearing. The report of incidence of cases this year to that of last year up to this time are 284 case to 484. The Norfolk area bearing the brunt of cases of poliomyelitis reported.

Since the unfortunate death of Dr. Albert McCown of this committee, Dr. Mason Romaine, the present state epidemiologist, has been serving on this committee in his capacity.

R. B. BOWLES, M.D.
E. A. HARPER, M.D.
ROBERT C. HOOD, M.D.
ROY M. HOOVER, M.D.
MASON ROMAINE, M.D.
LEE E. SUTTON, JR., M.D., *Chairman*

Federal Medical Services

Your Committee has been quite active during the year acquainting physicians over the state with medicine's position on the VA Medical Care Program. Members of the Committee spoke at a number of medical meetings, and also addressed several other groups.

The stand of the AMA, with respect to the care of the sick and injured veteran, was particularly stressed. Although covered in more detail in the September 1954 issue of the Virginia Medical Monthly (page 456) AMA's recommendations to Congress are repeated for the sake of emphasis:

"It was the considered opinion of the AMA House of Delegates that the AMA has a responsibility for the health and welfare of the entire population and not for just a particular segment, and it, therefore, recommended that the Congress enact legislation limiting VA medical care and hospitalization benefits to:

"(1) Veterans with peacetime or wartime service whose disabilities or diseases are service-incurred or aggravated, and to
"(2) Veterans with wartime service suffering from tuberculosis or psychiatric or neurological disorders of non-service connected origin, who are

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unable to defray the expenses of necessary hospitalization, provided that treatment is given within limits of existing facilities, and only until local facilities for such treatment are adequate.

"The AMA believes that the responsibility for medical care of veterans, unable to pay, rests with the state and local governments along with other citizens in similar circumstances and that facilities for the care of all citizens can be made available when the communities and states reclaim their responsibility from the federal government."

Members of the Committee are always available to any society wishing to discuss the Veterans' Medical Care Program, and its various aspects.

CHARLES M. CARAVATI, M.D., *Chairman*
JOHN O. BOYD, JR., M.D.
W. L. NALLS, M.D.
E. C. DRASH, M.D.
THOMAS W. MURRELL, M.D.
ROBERT L. PAYNE, M.D.

DELEGATES TO 1954 MEETING THE MEDICAL SOCIETY OF VIRGINIA

Where no name is listed, it is indicative that no delegate or alternate was reported.

Delegates	*Alternates*
Accomack	
Dr. Joseph L. DeCormis	Dr. Belle DeCormis Fears
Albemarle	
Dr. McLemore Birdsong	Dr. B. S. Leavell
Dr. H. L. Archer	Dr. J. R. Morris
Dr. C. N. Moon, Jr.	Dr. G. S. Fitz-Hugh
Dr. E. C. Drash	Dr. A. P. Booker
Dr. T. S. Edwards	Dr. Woodbury Perkins
Dr. R. E. Herring	Dr. H. C. McCoy
Alexandria	
Dr. Ben C. Jones	Dr. John D. Hoyle
Dr. Charles V. Amole	Dr. John A. Sims
Alleghany-Bath	
Dr. Armistead Williams	Dr. H. G. Hudnall
Dr. M. B. Jarman	Dr. S. P. Hileman
Amherst-Nelson	
Dr. Lyddane Miller	
Arlington	
Dr. H. C. Bates	Dr. John T. Hazel
Dr. W. C. Welburn	Dr. Lloyd B. Burk
Augusta	
Bedford	
Dr. W. V. Rucker	Dr. T. H. Jennings
Botetourt	
Buchanan-Dickenson	
Dr. T. C. Moore	Dr. J. P. Williams
Dr. T. C. Sutherland	Dr. J. P. Sutherland
Charlotte	
Dr. Stuart Wilson Tuggle	Dr. J. D. Wilson
Culpeper	
Dr. O. K. Burnette	Dr. C. G. Finney
Danville-Pittsylvania	
Dr. John R. Eggleston	Dr. Samuel Newman
Dr. W. C. Fitzgerald	Dr. G. V. Thompson
Fairfax	
Dr. J. D. Zylman	
Fauquier	
Dr. John Ringler	Dr. Robert Latimer
Floyd	
Fourth District	
Dr. A. Tyree Finch	
Dr. John G. Graziani	Dr. Ray Moore, Sr.
Dr. James M. Habel, Sr.	Dr. James T. O'Neal
Dr. Earl M. Bane	Dr. William B. Bishop
Dr. Henry B. Showalter	Dr. Kester S. Freeman
Dr. L. H. Bracey	Dr. H. H. Braxton
Fredericksburg	
Dr. W. W. Butzner, Jr.	Dr. J. L. Smoot
Dr. H. D. Crow	Dr. T. B. Payne
Halifax	
Dr. N. M. Ewell	Dr. W. Lloyd Eastlack
Hampton	
Hanover	
Dr. John D. Hamner, Jr.	
James River	
Dr. J. H. Yeatman	Dr. A. C. Whitley
Dr. E. J. Haden	Dr. W. A. Pennington
Lee	
Dr. G. B. Setzler	Dr. T. S. Ely
Loudoun	
Louisa	
Lynchburg	
Dr. George B. Craddock	Dr. John R. Saunders
Dr. Harold L. Riley	Dr. A. D. F. White

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Delegates	*Alternates*
Mid-Tidewater	
Dr. Joseph Chinn	Dr. J. M. Gouldin
Dr. Carl Broaddus	Dr. R. D. Bates
Dr. A. W. Lewis, Jr.	Dr. M. H. Harris
Dr. J. R. Parker	
Dr. B. H. Bailey	
Dr. Raymond S. Brown	Dr. H. A. Tabb
Dr. A. L. Van Name	Dr. T. L. Grove
Dr. H. L. Shinn	Dr. R. D. Bowles
Norfolk	
Dr. William H. Whitmore	Dr. John Franklin
Dr. Russell M. Cox	Dr. W. B. Hoover
Dr. Mallory S. Andrews	Dr. Harry Cox
Dr. John A. Cocke	Dr. M. Kirwan King
Dr. Kalford W. Howard	Dr. Mason C. Andrews
Dr. Forrest White	
Northampton	
Dr. John R. Freeman	Dr. Edmund Henderson
Northern Neck	
Dr. C. Harper Ward	Dr. Charles Griffith
Dr. Paul Pearson	Dr. Harold Sisson
Dr. J. Motley Booker	
Dr. A. B. Gravatt, Jr.	Dr. Lee Liggan
Northern Virginia	
Dr. Harold W. Miller	Dr. Frank Gearing, Jr.
Dr. M. J. W. White	Dr. George Long
Dr. Dennis P. McCarty	Dr. Elizabeth Sherman
Dr. H. Pearce Maccubbin	Dr. George Murphy
Dr. John P. Snead	Dr. Chester Riley
Dr. Frank Tappan	Dr. Thomas Iden
Orange	
Dr. J. G. Bruce, Jr.	
Patrick-Henry	
Dr. W. N. Thompson	
Dr. H. M. Price	Dr. J. H. Irby
Princess Anne	
Dr. Ira L. Hancock	Dr. Ralph Stata
Richmond Academy	
Dr. Benjamin W. Rawles, Jr.	Dr. P. D. Camp
Dr. Charles L. Outland	Dr. Russell G. McAllister
Dr. W. Linwood Ball	Dr. Gilman Tyler
Dr. R. D. Butterworth	Dr. William H. Hill
Dr. Wellford C. Reed	Dr. Carrington Williams, Jr.
Dr. William H. Higgins, Jr.	Dr. John D. Call
Dr. John P. Lynch	Dr. J. Robert Massie, Jr.
Dr. Adney Sutphin	Dr. Elam C. Toone
Dr. E. L. Kendig, Jr.	Dr. Oscar Hite
Dr. H. St. George Tucker, Jr.	Dr. Edwin Vaughan
Dr. Virgil R. May	
Dr. William R. Morton	Dr. L. James Buis
Dr. W. T. Thompson, Jr.	Dr. Robert V. Terrell
Dr. William Young	Dr. Elmer Robertson
Roanoke Academy	
Dr. Horace Albertson	Dr. John Martin
Dr. Collins D. Nofsinger	Dr. M. A. Johnson, III
Dr. R. S. Hutcheson, Jr.	Dr. John Walke
Dr. Conrad Stone	Dr. John Gardner
Dr. Allen Barker	Dr. Garrett Gooch
Dr. Wade H. Saunders	Dr. J. M. Bishop
Rockbridge	
Dr. O. H. McClung, Jr.	Dr. Thomas B. Hedrick
Rockingham	
Dr. Clifford T. Riddel, Jr.	Dr. C. S. Armentrout
Russell	
Scott	
Southwestern Virginia	
Dr. R. D. Campbell	Dr. J. J. Eller
Dr. G. B. Kegley	Dr. Rufus Brittain
Dr. Glenn Cox	Dr. W. A. Porter
Dr. E. L. Bagby	Dr. S. A. Tuck
Dr. Joseph Coates	Dr. W. V. Harrison
Dr. W. R. Chitwood	Dr. S. W. Huddle
Dr. W. F. Delp	Dr. C. G. Fox
Dr. R. L. Hillman	Dr. S. H. Catron
Dr. A. F. Giesen	Dr. A. M. Showalter
Tazewell	
Dr. Mary Elizabeth Johnston	
Tri-County	
Dr. E. F. Reese, III	Dr. G. G. Birdsong
Dr. W. H. Chapman	Dr. J. R. Ellison, Jr.
Dr. F. I. Steele	Dr. Hugh Warren
Dr. George J. Carroll	Dr. L. J. Stetson
Warwick-Newport News	
Dr. William A. Read	Dr. E. B. Mewborne
Dr. Russell Buxton	Dr. Fred N. Thompson
Williamsburg-James City	
Dr. B. T. Painter	Dr. Joseph Barrett
Wise	
Dr. W. B. Barton	Dr. J. T. Phillips

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Presidents of The Medical Society of Virginia

PRESIDENT	YEAR OF MEETING
*Dr. James McClurg, Richmond	1821
*Dr. William Foushee, Richmond	1822
*Dr. William Foushee, Richmond	1823
*Dr. James Henderson, Richmond	1824
Meetings Discontinued.	
*Dr. Robert William Haxall, Richmond	1841
*Dr. Robert William Haxall, Richmond	1842
*Dr. Frederick Marx, Richmond	1843
*Dr. Thomas Nelson, Richmond	1844
*Dr. William A. Patteson, Richmond	1845
*Dr. William A. Patteson, Richmond	1846
*Dr. John A. Cunningham, Richmond	1847
*Dr. William A. Patteson, Richmond	1848
	1849
*Dr. Robert William Haxall, Richmond	1850
*Dr. Beverley R. Wellford, Fredericksburg	1851
*Dr. James Beale, Richmond	1852
*Dr. Thomas P. Atkinson, Danville	1853
*Dr. Carter P. Johnson, Richmond	1854
*Dr. H. C. Worsham, Dinwiddie	1855
*Dr. H. C. Worsham, Dinwiddie	1856
*Dr. James Bolton, Richmond	1857
*Dr. Levin S. Joynes, Richmond	1858
Meetings Discontinued	
*Dr. R. S. Payne, Lynchburg	1870
*Dr. R. S. Payne, Lynchburg	1871
*Dr. A. M. Fauntleroy, Staunton	1872
*Dr. Harvey Black, Blacksburg	1873
*Dr. A. G. Tebault, London Bridge	1874
*Dr. S. C. Gleaves, Wytheville	1875
*Dr. F. D. Cunningham, Richmond	1876
*Dr. J. L. Cabell, University	1877
*Dr. J. H. Claiborne, Petersburg	1878
*Dr. L. S. Joynes, Richmond	1879
*Dr. Henry Latham, Lynchburg	1880
*Dr. Hunter McGuire, Richmond	1881
*Dr. G. W. Semple, Hampton	1882
*Dr. W. D. Cooper, Morrisville	1883
*Dr. J. E. Chancellor, Charlottesville	1884
*Dr. S. K. Jackson, Norfolk	1885
*Dr. Rawley W. Martin, Chatham	1886
*Dr. Bedford Brown, Alexandria	1887
*Dr. Benjamin Blackford, Lynchburg	1888
*Dr. E. W. Row, Orange C. H.	1889
*Dr. Oscar Wiley, Salem	1890
*Dr. W. W. Parker, Richmond	1891
*Dr. H. Grey Latham, Lynchburg	1892
*Dr. Herbert M. Nash, Norfolk	1893
*Dr. Wm. P. McGuire, Winchester	1894
*Dr. Robt. J. Preston, Abingdon	1895
*Dr. Wm. L. Robinson, Danville	1896
*Dr. Geo. Ben Johnston, Richmond	1897
*Dr. Lewis E. Harvie, Danville	1898
*Dr. Jacob Michaux, Richmond	1899
*Dr. Hugh T. Nelson, Charlottesville	1900
*Dr. J. R. Gildersleeve, Tazewell	1901
*Dr. R. S. Martin, Stuart	1902
*Dr. J. N. Upshur, Richmond	1903
*Dr. Joseph A. Gale, Roanoke	1904
*Dr. Wm. S. Christian, Urbanna	1905
*Dr. Lomax Gwathmey, Norfolk	1906
*Dr. Paul B. Barringer, Charlottesville	1907
*Dr. Wm. F. Drewry, Petersburg	1908
*Dr. Stuart McGuire, Richmond	1909
*Dr. E. T. Brady, Abingdon	1910
*Dr. O. C. Wright, Jarratt	1911
*Dr. Hugh M. Taylor, Richmond	1912
*Dr. Southgate Leigh, Norfolk	1913
*Dr. Stephen Harnsberger, Catlett	1914
*Dr. Samuel Lile, Lynchburg	1915
*Dr. Joseph A. White, Richmond	1916
*Dr. Geo. A. Stover, South Boston	1917
*Dr. Ennion G. Williams, Richmond	1918†
*Dr. Ennion G. Williams, Richmond	1919
*Dr. Paulus A. Irving, Farmville	1920
*Dr. Alfred L. Gray, Richmond	1921
*Dr. E. C. S. Taliaferro, Norfolk	1922
*Dr. John Staige Davis, University	1923
*Dr. W. W. Chaffin, Pulaski	1924
*Dr. Hunter H. McGuire, Winchester	1925
Dr. W. L. Harris, Norfolk	1926
*Dr. J. Shelton Horsley, Richmond	1927
*Dr. J. W. Preston, Roanoke	1928
*Dr. J. Bolling Jones, Petersburg	1929
*Dr. Charles R. Grandy, Norfolk	1930
*Dr. J. Allison Hodges, Richmond	1931
*Dr. I. C. Harrison, Danville	1932
*Dr. J. C. Flippin, University	1933
Dr. R. D. Bates, Newtown	1934
*Dr. F. H. Smith, Abingdon	1935
Dr. P. St. L. Moncure, Norfolk	1936
Dr. J. M. Hutcheson, Richmond	1937
*Dr. G. F. Simpson, Purcellville	1938
Dr. A. F. Robertson, Jr., Staunton	1939
*Dr. H. H. Trout, Roanoke	1940
Dr. W. B. Martin, Norfolk	1941
*Dr. Roshier W. Miller, Richmond	1942
Dr. J. M. Emmett, Clifton Forge	1943
*Dr. C. B. Bowyer, Stonega	1944
Dr. H. B. Mulholland, Charlottesville	1945
*Dr. Julian L. Rawls, Norfolk	1946
Dr. W. L. Powell, Roanoke	1947
Dr. Guy R. Fisher, Staunton	1948
*Dr. M. Pierce Rucker, Richmond	1949
Dr. W. C. Caudill, Pearisburg	1950
Dr. C. Lydon Harrell, Norfolk	1951
Dr. John T. T. Hundley, Lynchburg	1952
Dr. James L. Hamner, Mannboro	1953
Dr. V. W. Archer, Charlottesville	1954

*Deceased.

†Owing to influenza epidemic during World War I, the council met in 1918, and Dr. Williams was continued as President.

WOMAN'S AUXILIARY TO THE MEDICAL SOCIETY OF VIRGINIA

President—MRS. KALFORD W. HOWARD, *Portsmouth*
President-Elect—MRS. MAYNARD R. EMLAW, Richmond
First Vice-President—MRS. JAMES P. KING, Radford
Second Vice-President—MRS. M. H. HARRIS, West Point
Third Vice-President—MRS. SHEPPARD K. AMES, Cape Charles
Recording Secretary—MRS. LEE S. LIGGAN, Irvington
Corresponding Secretary—MRS. LEMUEL E. MAYO, Portsmouth
Treasurer—MRS. WILLIAM C. BARR, Richmond
Parliamentarian—MRS. M. C. GLOVER, Arlington
Historian—MRS. C. M. McCOY, Norfolk

The Thirty-second annual meeting of the Woman's Auxiliary to The Medical Society of Virginia, meeting with the First Interstate Scientific Assembly, will be held at the Shoreham Hotel, Washington, D. C., on Tuesday, November 2nd, at 9:15 A. M.

A most cordial invitation is extended to all women who are Auxiliary members or guests of physicians attending the Scientific Assembly to participate in all social functions and to attend the General Annual Meeting. All wives of doctors will be welcomed.

HEADQUARTERS — SHOREHAM HOTEL

Registration, Lower Main Lobby, Shoreham Hotel
Sunday, October 31st, 3:00 - 7:00 P. M.
Monday, November 1st, 10:00 A. M. - 4:00 P. M.
Tuesday, November 2nd, 9:00 - 10:30 A. M.

Each lady is urged to register promptly on arrival.

The District of Columbia Women's Medical Society have offered their suite for the use of the Auxiliary ladies during the Convention, except after 3 P. M. on Monday.

COMMITTEES

Arrangements—Chairmen
MRS. LAWRENCE A. RAPEE, Washington
MRS. EUGENE GRETHER, Alexander
MRS. LEE B. MARTIN, Arlington

Co-Chairmen
MRS. CHRISTOPHER J. MURPHY, JR., Alexandria
MRS. ANTHONY DiSARIO, Arlington

Corresponding Secretary
MRS. RICHARD PALMER, Alexandria
MRS. HERMAN DIAMANT, Arlington

Convention Treasurer
MRS. FORREST M. SWISHER, Arlington

Publicity
MRS. HERBERT SCHOENFIELD, Washington
MRS. JAMES MOSS, Alexandria
MRS. ROBERT MITCHELL, Arlington

Luncheon
MRS. HOWARD DONALD, Washington
MRS. WILLIAM WEAVER, Alexandria
MRS. K. CHARLES LATVEN, Arlington

Fashion Show
MRS. CHARLES TEGGE, Washington
MRS. JOHN HOYLE, Alexandria
MRS. A. J. ORLOSKY, Arlington

Hospitality
MRS. J. R. B. HUTCHINSON, Arlington
MRS. CHRISTOPHER J. MURPHY, JR., Alexandria

Pages
MRS. CLARK BATES, Arlington
MRS. FRANK RIPBERGER, Alexandria

Transportation
MRS. M. W. GLOVER, Arlington

Credentials and Registration
MRS. ROBERT DETWILER, Arlington

Timekeeper
MRS. CLYDE W. VICK, JR., Petersburg

Chairman of Tellers
MRS. C. C. HATFIELD, Saltville

PROGRAM

Monday, November 1st

10:00-11:00 A.M.—The Mead Johnson Coffee Hour, Lower Main Lobby, Shoreham Hotel, the Woman's Auxiliary to the Medical Society of the District of Columbia, Hostesses
Mrs. Edgar Quayle, Chairman

2:00 P.M.—Pre-Convention Board Meeting, Suite 100C, Shoreham Hotel
Presidents and Presidents-Elect of Component Auxiliaries, State Officers and Chairman of Standing and Special Committees are expected to attend.

Tuesday, November 2nd

9:15 A.M.—General Annual Meeting, Louis Seize Room, Shoreham Hotel.
Mrs. Kalford W. Howard, President, presiding.
Invocation—Mrs. Hawes Campbell, Convention Chaplain
Address of Welcome—Mrs. Richard H. Todd, Immediate Past-President, Woman's Auxiliary to the Medical Society of the District of Columbia
Response—Mrs. James P. King, First Vice-President
In Memoriam—Mrs. Hawes Campbell
Minutes
Roll Call
Presentation of Honored Guests
President's Report
Report of Officers
Reports of Chairmen of Standing and Special Committees
Report of Councilor to Southern
Reports of County Auxiliary Presidents
Award of Membership Prizes—Mrs. Maynard R. Emlaw
Report of Credentials Committee—Mrs. Robert Detwiler
Report of Annual Convention of the Woman's Auxili-

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ary to A. M. A.—Mrs. Richard M. Reynolds, National Public Relations Chairman
Address—Mrs. George D. Feldner, President, Woman's Auxiliary to the Southern Medical Association
Address—Mrs. George Turner, President, Woman's Auxiliary to the American Medical Association
Unfinished Business
New Business
Recommendations from the Board
Report of Committee on Revisions—Mrs. Paul Pearson
Report of Resolutions Committee—Mrs. Frederick L. Finch
Report of Nominating Committee—Mrs. Thomas N. Hunnicutt, Jr.
Election of Officers
Installation of Officers—Mrs. George Turner, President, Woman's Auxiliary to the American Medical Association
Adjournment

LUNCHEON

1:15 P.M.—First Interstate Assembly Women's Auxiliary Luncheon, Continental Room, Sheraton Park Hotel
Presided over by Mrs. Duane Richmeyer, President, Woman's Auxiliary to the Medical Society of the District of Columbia, and Mrs. Kalford W. Howard, President, Woman's Auxiliary to The Medical Society of Virginia
Invocation—Mrs. Hawes Campbell, Convention Chaplain
Presentation of Honored Guests
Greetings from Mrs. George D. Feldner and Mrs. George Turner
Presentation of Virginia Gavel and President's Pin
Acceptance
Presentation of Past-President's Pin—Mrs. Thomas N. Hunnicutt, Jr.
Luncheon
Fashion Show
Adjournment

Wednesday, November 3rd

8:30 A.M.—Past President's Breakfast, Suite 100B, Shoreham Hotel, Mrs. Thomas N. Hunnicutt, Jr., Chairman
9:30 A.M.—Post-Convention Board Meeting, Suite 100C, Shoreham Hotel, Mrs. Maynard R. Enlaw presiding
Presidents and Presidents-Elect of Component Auxiliaries, State Officers and Chairmen of Standing and Special Committees are expected to attend.

The Alexandria and Arlington Auxiliaries cordially invite and welcome the members and guests of the Woman's Auxiliary to The Medical Society of Virginia to the 32nd Annual Meeting and the First Interstate Scientific Assembly. This is to be held in conjunction with the Woman's Auxiliary to the Medical Society of the District of Columbia at the Shoreham Hotel in Washington, D. C., on October 31st, November 1st, 2nd and 3rd.

MRS. EUGENE R. GRETHER, *Alexandria Chairman of Arrangements*

MRS. LEE B. MARTIN, *Arlington Chairman of Arrangements*

MRS. CHRISTOPHER J. MURPHY, JR., *Alexandria Co-Chairman*

MRS. ANTHONY DISARIO, *Arlington Co-Chairman*

Southern Medical Association.

This is a cordial invitation to Virginia auxiliary members to attend the Thirtieth Annual Meeting of the Woman's Auxiliary to the Southern Medical Association in St. Louis, Missouri, November 8-10, 1954. Many novel and interesting features of entertainment have been planned for us by Mrs. Edmund S. Beckette, General Chairman, and her able committee. Among the events are the following:

Monday, November 8—*Tea,* at 3:00 p.m. in Japanese Tea Garden, Missouri Room, Hotel Statler

Tuesday, November 9—*General session*—9:30 a.m. —16th Floor, Hotel Statler, Mrs. George D. Feldner, President, presiding.
Annual Doctor's Day Luncheon—1:00 p.m., Ballroom, Hotel Statler. This is especially to honor our doctors and all members are urged to bring their husbands. There will be no guest speaker but awards for Doctor's Day contest will be made.

Wednesday, November 10—*Closing session*—10:00 a.m., 16th Floor, Statler, Mrs. Feldner, President, presiding. Our National President, Mrs. George Turner, will be guest speaker.
Annual Dinner Dance—7:00 p.m., Gold Room, Jefferson Hotel.

A warm welcome awaits you in St. Louis and I hope to see many of our Virginia members there.

LUCIA K. EMLAW (Mrs. Maynard R.)
Third Vice-President, Woman's Auxiliary to Southern Medical Association

EDITORIAL

The Challenge of the Ever Increasing Need for Nursing Care

HOSPITALS are confronted with the problem of increase in numbers of patients; increase in the demands for technical service for the patients; and with the problem of obtaining and retaining an adequate supply of nursing personnel.

The nursing profession is aware of these problems as is the American Medical Association and the American Hospital Association. Perhaps one of the best things that has come out of the problem of meeting the increase in nursing needs of our country has been the cooperative spirit that has grown up in all groups of health workers. The American Medical Association, the American Hospital Association, the American Nurses' Association, and the National League for Nursing are working together to try to increase the supply of nurses and to make sure that professional nurses are given the opportunity to utilize their nursing skill. Examples of such efforts can be seen in the various nursing school recruitment programs; in studies, institutes, and workshops that are being made for better utilization of the "on the job trained worker" as well as for the better utilization of the professional nurse; also on the increasing emphasis being placed in the nursing students curriculum on the problem of meeting the emotional, physical and spiritual needs of the patient through cooperating with other workers.

A few years ago when one nurse was expected to give complete care to a few patients it was a relatively easy matter for the nurse to learn her patients and to recognize their moods. When the patient remained in the hospital over a prolonged period of time the nurse had time to become acquainted with the patient. Today this problem is much greater for the nurse because our patients' hospital stay is shorter; also because there are increased technical demands on the nurse. Many technical devices are used today which were unknown a few years ago, or if known were rarely used or were performed by the doctor. These technical duties absorb the nurses time and attention and give her less time to spend talking to her patient. The increased number of patients to be cared for by the nurse necessitates help from other sources if the patient is to be bathed, fed, and have the bodily needs met. Hospitals have therefore brought in the lay person to assist in this job. These persons with on the job training have been of tremendous help in meeting the nurse shortage but in many instances they are not equipped to recognize and meet the patients emotional needs. For example, the pre-operative patient is usually frightened. It is not enough to say, "You are going to be all right". The patient needs some explanations as to the type of operation or treatment and what to expect. The surgeon or physician usually gives this to the patient but the patient will think it through and will want a further explanation after the doctor has left.

The understanding nurse gives the patient a chance to talk of his fears and she tries to make him see that his apprehension is not unusual. She explains that the patient will receive medicine the day of the operation to make him relax and that when he returns from the operating room he will awaken in the oxygen tent which will aid in supplying oxygen to the body and thus decrease the strain on the vital organs. This need for explanation is equally important for medical patients and for all stages of the patients treatment, convalescence, and discharge.

If the nurse is to inspire the patient's confidence in the physician, the hospital, and the nurses and if she is going to meet his emotional needs she must have a full knowledge of the doctor's plan of treatment and reactions to be expected. She must

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have a warm understanding personality and a knowledge of the patient's psychological needs. As important as the physical needs of any patient are the psychological needs. The pills and hypodermics may be given on time and treatments and dressings applied with a skilled hand, but if the patient feels frightened, frustrated and alone, the recovery is retarded and we are not meeting patients needs. Skill in meeting patients emotional needs is developed through study of the social sciences and a concentrated effort on the part of the nurse. More emphasis in the School of Nursing curriculum is being placed on the social sciences but we need to continue to strengthen this aspect.

Occasionally we hear criticism that the young nurses of today do not have the interest of the patient at heart as nurses used to do; they only want to get off duty on time. We know this cannot be true when we see young nurses giving of their time, effort, and even of their limited money to help some patient in distress. Numerous examples can be cited but I will only name a few.

An out-of-state patient with very little money and no relatives near by to visit her was in the hospital for months. A young student nurse on that ward, knowing the patient was alone and with limited funds, began taking the patient's gowns home to wash and iron them in her time off duty. Not only did she do this during the period she was assigned to this ward but even after she was moved to another assignment she continued to come back and do this patient's laundry. While this act was of material help to the patient, the knowledge that someone cared enough to perform this act of love meant more to the patient than words can tell.

A ten year old orphan was admitted to the hospital for some surgery. She had 73 cents in her pocketbook which she confided to the nurse that she was saving to buy herself a suit. She stated she had always wanted a suit and while she knew she would not be able to save enough money to get herself one this Easter, she would some day have that suit. The nurses decided that she should have that suit now. One nurse who could sew cut down a suit that she had outgrown and made it to fit this patient; one bought her a blouse; one shoes; one a hat and the other a pocketbook. The little girl was discharged a couple of days before Easter and she left in her new outfit and with the happiness that only a ten year old who is realizing a cherished dream can experience.

We can find daily examples of our students and young nurses staying overtime to write letters, to take patients to church or downtown or making little gifts to patients who are old or alone. So long as we see such examples of generosity and unselfishness we need have no fear that the spirit of nursing is being lost. We need provide assistance in its development through our educational programs in our schools and through healthy relationships in our practice fields or hospitals.

With the tremendous increase in demand for nursing care that has appeared during the past twenty years we cannot possibly hope to provide the same number of professional nurse hours per hospital patient as was commonly expected in the thirties. If we did so there would be few, if any, women entering other professions and few left to marry to become homemakers and mothers. Our only hope is to continue to attract as many as possible who have the necessary qualifications to enter professional nurse schools. In addition to the problem of recruiting or attracting prospective nursing students, there is the problem of financing the education of those who have qualifications but not the money. Much has been done in recent years to provide financial assistance, not only by the state but by philanthropic individuals and groups of individuals. There is, however, still need for more assistance of this kind.

We need to make our nursing schools truly educational so that each graduate is prepared to meet the total patient needs, to direct the activities of those working with

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her, and to live in such a way that she derives professional and personal happiness and satisfaction in her work which will make her wish to continue in it. We need to attract those persons with suitable personalities and qualifications for nursing who either do not have the required academic background for professional nursing or who do not wish to take the necessary time for the professional nurse program to enter practical nurse schools. We need to continue to seek ways and means of improving these practical nurse schools so that the students receive the best possible preparation. We need to continue to select and employ lay workers to assist in patient care and these workers need thorough and careful on the job training. After bringing all of these groups together we need a continual in-service education program for our hospitals, not only for our nursing personnel but for all groups of workers. Unless there is job satisfaction we cannot expect to retain our workers, whether nurses or other personnel, and job satisfaction goes further than just salary. Perhaps the most important element in job satisfaction is good inter-personal relations where each individual feels she is making a worthwhile contribution which is duly appreciated.

Roy C. Beazley, R.N.

Editor's Note: Miss Beazley is Acting Co-Chairman, Department of Nursing, University of Virginia and Director, Nursing Service, University of Virginia Hospital.

NEWS

Calendar of Coming Events

Evening Medical Lectures—University of Virginia, School of Anatomy, Charlottesville, October 25. Dr. John C. Cutler, Washington, D. C., "Experimental Human Inoculation with Syphilis"

National Gastroenterological Association—Shoreham Hotel, Washington, D. C., October 25-27

Fifth National County Medical Societies Civil Defense Conference—Bismarck Hotel, Chicago, October 30-31

The Medical Society of Virginia—(Annual Meeting)—First Interstate Scientific Assembly—Shoreham Hotel, Washington, D. C., October 31-November 3

Evening Medical Lectures—University of Virginia, School of Anatomy, Charlottesville, November 8. Dr. Lawrence E. Young, Rochester, N. Y., "Some Newer Concepts of Hemolytic Disorders"

Southern Medical Association—St. Louis, Missouri, November 8-11

American College of Surgeons—Clinical Congress—Atlantic City, N. J., November 15-19

American Medical Association—Clinical Meeting—Miami, Florida, November 29-December 2

Second Annual Conference on Therapy—University of Virginia Medical School, December 10, 9:00 A.M.-5:00 P. M.

Southern Medical Association.

Arrangements for the forty-eighth annual meeting of this Association in St. Louis, November 8-11, are about complete. The meeting begins with a general public session on the 8th, and between that time and Thursday noon, the 11th, forty-eight half-day sessions will be held.

Dr. Alphonse McMahon, St. Louis, is president

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of the Association, and Dr. Daniel L. Sexton is serving as general chairman of the Committee on Arrangements.

Requests for room reservations for the meeting should be sent to the Housing Bureau, Southern Medical Association, 911 Locust Street, Room 406, St. Louis 1, Missouri.

Absentee Voting.

Another election year is with us and unfortunately the First Interstate Scientific Assembly (Annual Meeting) conflicts with election day—November 2. However, there is no need for a physician to miss the meeting in order to cast his vote. It is a simple matter to vote by absentee ballot, and the procedure to be followed is outlined for your convenience.

(1) Secure an absentee ballot application from the State Board of Elections, Capitol Building, Richmond.
(2) Complete the application in the presence of a witness, and
(3) Send it, with 3¢ to your local precinct registrar. If you are a qualified voter, a ballot will be sent you by registered mail.
(4) After voting, return the ballot by registered mail.

Should you reside in Richmond, the procedure is very simple. Merely go to the Registrar's Office, City Hall Basement, where you can fill out a form and vote before a notary. This takes a very few minutes, and can be done any time after September 20. It is quite likely that this same procedure can be followed by residents of the larger cities.

Be sure that ballot applications reach your registrar before October 25!

Dr. Eckles Named Health Director.

Dr. Beverley F. Eckles, Galax, has been named as health director for Henrico County, succeeding the late Dr. Blesse. He began his duties on October 1st. Dr. Eckles is a native of Richmond and practiced there for fifteen years when he moved to Galax in 1928.

Governor for American Diabetes Association.

Dr. William R. Jordan, Richmond, has been appointed Governor for the Commonwealth of Virginia for the American Diabetes Association.

Dr. Mettauer Again Honored.

The recently completed addition to the Southside Community Hospital, Farmville, has been named the Mettauer Ward in honor of Dr. John Peter Mettauer, noted physician, surgeon and patriot. The dedication ceremonies took place on August 29th, and Dr. Wyndham B. Blanton, Richmond and Cumberland, spoke on Dr. Mettauer. A portrait was presented to be hung in the public area of the new wing.

Dr. Ernest R. Trice,

Captain, M.C., U. S. Army, on duty at Osaka Army Hospital, was awarded the Bronze Star on August 16th.

Dr. L. O. Fears, Jr.,

Former director of the Carroll-Grayson Health District, was transferred to the Page-Warren-Shenandoah Health District on August 16, 1954.

The Gill Memorial Eye, Ear and Throat Hospital

Will hold its 28th Annual Spring Congress in Opthalmology and Otolaryngology in Roanoke, April 4-9, 1955.

Among the guest speakers who will attend are: Drs. Henry L. Birge, Hartford, Conn.; Paul Boeder, Southbridge, Mass.; William B. Clark, New Orleans; Dan M. Gordon, New York; Anderson C. Hilding, Duluth, Minn.; Chevalier L. Jackson, Philadelphia; Bertha S. Klein, Chicago; T. G. Martens, Rochester, Minn.; Daniel S. Miller, Boston; Major General Daniel Ogle, Washington; Thomas Paine, Ann Arbor; R. Townley Paton, New York; James Purnell, New York; Albert D. Ruedeman, Detroit; Robert E. Ryan, St. Louis; Richard Schneider, Ann Arbor; John Sheldon, Ann Arbor; and Grant Ward, Baltimore.

Dr. Thomas S. Edwards

Announces his association with Dr. Harvey D. Smallwood for the practice of internal medicine. Their offices are at 1021 West Main Street, Charlottesville.

Dr. A. M. Tiernan,

Recently of Jewell Ridge, is now at the Louisville General Hospital, Louisville, Kentucky, where he is taking a residency in ophthalmology.

Van Meter Prize Award.

The American Goiter Association again offers the Van Meter Prize Award of Three Hundred Dollars and two honorable mentions for the best essays submitted concerning original work on problems related to the thyroid gland. The award will be made at the annual meeting of the Association which will be held

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in Oklahoma City, Oklahoma, April 28, 29 and 30, 1955, providing essays of sufficient merit are presented in competition.

The competing essays may cover either clinical or research investigations; should not exceed three thousand words in length; must be presented in English, and a typewritten double space copy in duplicate sent to the Secretary, John C. McClintock, M.D., 149½ Washington Avenue, Albany, New York, not later than January 15, 1955.

Dr. Samuel H. Carter

Has been released from active military duty and has opened his office in Verona for the general practice of medicine.

Dr. Maury C. Newton, Jr.,

Is now associated in practice with his father at Narrows. He is a graduate of the Medical College of Virginia and for the past year has been on the House Staff there as a recipient of the Mead Johnson General Practice Award.

Dr. L. E. Dunman,

Pearisburg, has been named to the school trustee electorial board of Giles County.

Dr. Samuel Richman,

Chief of Radiological Service at McGuire Veterans Hospital, Richmond, for the past eight years, has resigned to assume private practice in radiology in Greensboro, North Carolina.

For Sale.

Complete office equipment, including fluoroscope, two sterilizers, metabolism machine, etc., in excellent condition. Owned by general practitioner, recently deceased. Contact Mrs. J. Edward Amiss, Altavista, Virginia. (*Adv.*)

For Sale.

X-Ray view box, practically new; cassettes all sizes and wire film hangers, all in good condition. Also portable x-ray machine, General Electric, for electric current 25 cycle—250 volt. Contact Dr. T. W. Hankins, Swoope, Virginia. (*Adv.*)

Location Wanted.

General Practitioner, qualified in surgery, age 31, to be released from Army February 1955, desires to associate with another physician or with small group in Virginia town of 5,000-20,000. For details, write Box 200, % Virginia Medical Monthly, P. O. Box 5085, Richmond 20, Virginia. (*Adv.*)

For Rent.

Excellent opportunity for physician just outside Washington in expanding community of Alexandria. Complete 5-room house available for use as office in area needing services of a physician. Owners willing to assist doctor in getting started. Telephone Mr. Charles Gerstain, Temple 6-9378, Washington, D. C., for appointment. (*Adv.*)

Heredity Theory of Epilepsy.

Epilepsy may be associated less with heredity than with complications before, during and just after birth, two Baltimore physicians reported in the June 19th Journal of the American Medical Association. A study of 396 epileptics and 393 non-epileptic children "raises doubts" as to the family-pattern theory of epilepsy. "The results of this study appear to indicate that there exists a relationship between certain abnormal conditions associated with childbearing and the subsequent development of epilepsy in the offspring."

Records of more than 500 epileptic children born in Baltimore between 1935 and 1952 showed "significantly more complications of pregnancy and delivery, prematurity and abnormal neonatal conditions" than a similar number of matched control births. "These abnormalities were just as frequent among epileptic children whose parents did or did not have epilepsy." The pattern of epilepsy in relation to mishaps in pregnancy or birth is similar to that already reported in cerebral palsy. This indicates that epilepsy should be added to the list of "reproductive casualties" that includes stillbirth, death of the newborn, and palsy.

The physician suggested one of the reasons for the theory of family transmission of epilepsy is that premature births tend to run in families and that a large number of the epileptic births are premature. They said their findings should be considered in attempts to improve conditions of maternal health and for the study of certain neuropsychiatric disorders.

The study, aided by grants from the Foundation for Mentally Retarded and Handicapped Children and the Civitan Club of Baltimore, was made by Drs. Abraham M. Lilienfeld and Benjamin Pasamanick, of the Johns Hopkins School of Hygiene and Public Health.

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OBITUARIES

Dr. John Powell Williams,

Widely known Richmond physician, died September 1st, at the age of fifty-nine. He was chief of medical services at McGuire Veterans Administration Hospital. Dr. Williams received his medical degree from the University of Virginia in 1923. During World War II, he served as chief of medical service and unit director of the Forty-Fifth General Hospital in North Africa and Italy. He held the rank of Colonel in the medical corps and was awarded the Legion of Merit. Dr. Williams was professor of clinical medicine at the Medical College of Virginia. He was a member of the State Medical Advisory Committee for Civil Defense and was chairman of the Richmond Academy of Medicine Advisory Committee to Selective Service. Dr. Williams was a member of many medical organizations, having served as president of the Constantinian Society and the Virginia Section of the American College of Physicians. He had been an active members of The Medical Society of Virginia since 1925, at one time serving as chairman of the committee for National Emergency Medical Service. His wife and two children survive him.

Dr. John Lloyd Tabb, Jr.,

Prominent radiologist of Richmond, died September 1st after a brief illness. He was a native of Gloucester County and sixty-one years of age. Dr. Tabb graduated from the Medical College of Virginia in 1916, following which he served in France during World War I. He was chief radiologist at St. Luke's Hospital where he had been a member of the staff since 1924. Dr. Tabb was also roentgenologist at the Crippled Children's Hospital and associate professor of radiology at the Medical College of Virginia. He was a member of many professional organizations and a past president of the Radiological Society of Virginia. Dr. Tabb had been an active member of The Medical Society of Virginia since 1917. His wife and two sons survive him.

Dr. Lemuel Leslie Eley,

Well known physician of Chuckatuck died August 20th, having been in failing health for about a year. He was eighty-three years of age and a graduate in medicine from the University of Maryland in 1891. Dr. Eley had practiced in Nansemond County for the past sixty-three years and had continued his practice until the week he died. He was prominent in civic affairs and served as a member of the Nansemond County School Board for a number of years. Dr. Eley was a Life Member of The Medical Society of Virginia, having joined in 1905. His wife and three children survive him.

Dr. Heber Jones Morton,

Stuarts Draft, died in a New York hospital on August 10th after a long illness. He was seventy years of age and received his medical degree from the University of Georgia in 1909. Dr. Morton had practiced in Augusta County for twenty-two years. He was a surgeon for the N. & W. Railway. Dr. Morton took an active part in American Legion activities, having served in the Medical Corps during World War I. He was a Royal Arch Mason, a past president of the Augusta County Medical Society and had been a member of The Medical Society of Virginia for twenty-three years. His wife and two sisters survive him.

Dr. J. Thomson Booth,

Ashland, died August 26th, at the age of sixty-nine. He was formerly a member of The Medical Society of Virginia. His wife and two daughters survive him.

Dr. William Sampson Hadley,

Norfolk, died July 30th at the age of fifty-six. He graduated from Jefferson Medical College in 1921. Dr. Hadley was formerly a member of The Medical Society of Virginia. His wife and a son survive him.

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